



Division of Licensing  
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ICENSING  
STANDARDS  
Department of Mental Health &  
Mental Retardation-Division of Licensing

INTRODUCTION

"A regulation is justifiable if it offers more advantage than the economic waste that it entails. Voluntary standards, if they exist, may avoid government regulation. One of the first advantages of standardization is that it enables public authorities to limit regulations to cases where compulsion is essential. Standardization thus economizes on the making of regulations. Government departments are thereby relieved of a mass of detailed work based on thousands of minor decisions."<sup>1</sup>

The Division of Licensing of Maine's Department of Mental Health and Mental Retardation (DMHMR) is responsible for conducting licensing reviews of mental health services in the State of Maine. The mission of the Division of Licensing is as follows:

To assure the public trust in the mental health and mental retardation service delivery systems, through the application of effective, efficient, equitable, and predictable monitoring, evaluation and improvement processes. Licensing seeks to assure that agencies have an adequate capacity to provide services. It evaluates agency and client management practices, including compliance with client rights protocols.

Given this mission and philosophy, the Division of Licensing has developed these Licensing Standards and Guidelines. These standards and guidelines are the product of over four years of work by a variety of individuals including consumers, family members, providers, legislators, advocates, consultants, DMHMR staff, and representatives from other state departments and bureaus.

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<sup>1</sup> Deming, W. Edwards: *Out of the Crisis*, Cambridge, MA: Massachusetts Institute of Technology, pp. 298-299, 1982.

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#### LEGAL AUTHORITY AND SCOPE

These regulations are promulgated under authority of 34-B M.R.S.A. s603, 3606 and apply to the following:

- ! all mental health agencies, facilities, or programs as defined by 34-B M.R.S.A. s3601, 3606, or;
- ! all mental health agencies, facilities, or programs funded by either the Bureau of Mental Health or the Bureau of Children with Special Needs for the provision of mental health services.

Excluded from these regulations are the following:

- ! agencies receiving funds from the Department of Mental Health and Mental Retardation solely for service not contained within the definition of 34-B M.R.S.A. 3601(2); and
- ! agencies licensed according to 34-B M.R.S.A. 1203(5).

## DEFINITIONS

<b>AMHI Consent Decree</b>	The Settlement Agreement, signed in July 1990, that represents the resolution of a fifteen count complaint arising from conditions at the Augusta Mental Health Institute.
<b>Assessment</b>	The process of evaluating an individual's strengths and service needs.
<b>Client</b>	An individual who uses licensed services.
<b>Commissioner</b>	The Commissioner of the Department of Mental Health and Mental Retardation for the State of Maine.
<b>Community support services</b>	Services designed to promote the mental health and community integration of people in the setting and community of their choice.
<b>Controlled drugs</b>	Schedule II and narcotic drugs.
<b>Crisis</b>	A situation or condition that has a high probability of leading to an emergency if left unaddressed.
<b>Crisis intervention</b>	A service designed to address crises.
<b>Crisis residential services</b>	A residential service designed to provide temporary shelter and respite for individuals experiencing crisis.
<b>Discharge Summary</b>	See transfer summary.
<b>Division</b>	The Division of Licensing of Maine's Department of Mental Health and Mental Retardation.
<b>Emergency</b>	A situation in which a person is dangerous to him/herself or others or at imminent risk of severe physical injury or mental deterioration to the point where they cannot care for themselves.
<b>Family</b>	Biological or legal family members or persons that the client define as family members.
<b>Governing body</b>	An assembly of persons that is legally constituted to oversee the operation of an organization. This assembly is often said to have fiduciary duties to the organization. Fiduciary duties encompass two basic legal obligations: the duty of care; and the duty of loyalty.
<b>Home-based services</b>	Services designed to be delivered in a person's home.
<b>Informed consent</b>	Consent, preferably in writing, obtained from a client for a specific procedure. Elements of a valid informed consent

include the following: the diagnosis, the nature and purpose of the procedure(s) for which consent is sought, all material risks and consequences of the procedure(s), an assessment of the likelihood that the procedure(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s), and the prognosis if no treatment is provided.

<b>Inpatient services</b>	Twenty-four hour, residential, hospital-based services.
<b>Initiation of service</b>	The point at which the client and provider agree on and deliver services.
<b>Least restrictive alternative</b>	The least intrusive service or treatment that can effectively and safely address the client's needs and stated preferences.
<b>Legally responsible party</b>	An adult client, or guardian of an adult ward, or a legally emancipated minor, or the legally responsible parent, guardian, or custodian of a minor, or other parties identified by applicable laws governing legal consents.
<b>Occurrence report</b>	A written document that reflects an occurrence, unusual problem, incident, deviation from standard practice, or situation that requires follow-up action.
<b>Outpatient services</b>	Services delivered in non-residential settings.
<b>Personnel record</b>	Files that commonly contain information related to employee, volunteer or student employment status, job performance and benefits.
<b>Quality management</b>	Management processes designed to improve the quality of care or services within an organization.
<b>Residential services</b>	Services delivered in a structured residence other than the client's home or a hospital.
<b>Screening</b>	A process for determining a client's eligibility

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<b>Supervision</b>	Guidance and/or direction provided either administratively or clinically.
<b>Transfer summary</b>	A brief description of the client's course of treatment or service that also contains recommendations for further treatment and/or service.
<b>Transition services</b>	Services designed to facilitate an individual's transition from one service, setting, or provider to another.

## THE LICENSURE PROCESS

All agencies that are found in substantial compliance with the core standards will be issued a Mental Health Agency License. The license will list each of the service-specific standards with which the agency will have been found to be in substantial compliance in the operation of services and/or programs. The decision as to which service-specific standards are to be applied to which programs or services will be made jointly by the Division of Licensing and the agency in preparation for the licensure survey.

It is the Division of Licensing's intention to make the licensure process as fair and consistent as possible for all applicants pursuing mental health licensure. In order to achieve this, we have developed the following

protocols to assist all applicants toward this end.

Technical assistance is offered to all applicants on an informal and formal basis and provides agencies with education and consultation through a variety of means. Technical assistance tools have been prepared for this purpose. We provide technical assistance through on-site meetings and training sessions, telephone consultation and written correspondence.

New applicants and agencies preparing to deliver a new service are permitted a six month period from the receipt of their application until actual licensure. Technical assistance is provided in order to clarify licensing requirements and assist in preparation for the site review. All agencies are held accountable for compliance with all licensing standards.

Agencies that currently hold a Mental Health Agency License will be notified of the availability of technical assistance six months prior to the license expiration date. Three months before the license expires, Licensing will forward an application packet to the agency. Upon receipt of the completed application packet, Licensing will contact the agency to set up the actual site review.

While all agencies are required to comply with all regulatory requirements, protocols have been established to allow agencies to apply for waivers of one or more of these requirements. These protocols include a waiver process, deemed status and affiliated service agreements.

Upon completion of the licensure survey, Licensing will prepare a site review report that includes recommendations regarding licensure status. The license which will accompany the report will be signed by the Director of the Division of Licensing and the Commissioner of the Department of Mental Health and Mental Retardation. The Commissioner holds the ultimate authority to issue or deny licensure as well as to waive specific requirements and to award deemed status.

The site review report is a comprehensive document that contains agency identifying information, services and programs reviewed, services to be listed on the license, a list of deficiencies, consultative comments and commendations. All items will address regulatory requirements. New providers achieving an initial license will be issued a provisional license, for a maximum of one year. Providers found in significant non-compliance with the standards will be issued a conditional license for a maximum of one year, pursuant to 34-B-MRSA, at the end of which time they will either achieve substantial compliance or face the loss of the license.

The completed site review report will be forwarded to the agency's Executive Director as well as the governing body President. Accompanying the report will be a plan of correction form for the agency to complete and return to Licensing. The process is designed to insure that deficiencies are resolved in a timely manner and to enable Licensing to provide, if indicated, technical assistance regarding the agency's corrective actions.

Also accompanying the site review report is a Satisfaction Survey. This survey is designed to identify both strengths and weaknesses in the licensing process, standards and reviewers. The responses are forwarded directly to the Director of the Division of Quality Management in order to enable agencies to comment freely about the licensing process. Information from these questionnaires is entered into a database and de-identified reports are periodically produced in order to review and improve all aspects of the licensing process.

Providers who find themselves in disagreement with either a finding of the Division of Licensing or the interpretation of a licensing standard are encouraged to request an appeal of the finding. The opportunity exists a formal review by the Commissioner of the Department of Mental Health and

Mental Retardation.

The Division will continue to develop and review policies and procedures, review standards for current appropriateness and work to improve the licensing process. Consultative comments from all interested persons will be considered in our ongoing effort to continue to be as fair and consistent as possible.

#### **LICENSING ELIGIBILITY CRITERIA**

Organizations seeking licensure by the Division of Licensing must meet the following criteria:

- ! The organization is incorporated.
- ! The organization and/or its components deliver, or expect to deliver, mental health services in the State of Maine.
- ! The organization must demonstrate that it will be able to secure enough funds for the first year of operation, e.g., budgets, letters of agreement, credit lines, endowment funds, donations.
- ! The organization must have a site from which it administers and/or delivers mental health services that are approved for occupancy.

#### **CORE STANDARDS**

The standards listed on pages 1 through 32 constitute the *core* mental health standards. That is, all mental health services with the exception of social clubs are required to comply with these standards. These core standards, in addition to any other program specific standards applicable to your agency, will be applied during the licensing survey. The core standards are divided into two major sections: agency management and clinical management.

#### **AGENCY MANAGEMENT**

Management in health service organizations can be broken into five general functions: planning, organizing, staffing, directing, and controlling. This section presents the core facility management standards arranged according to these general management functions.

## **Planning**

Planning is an orderly process for giving organizational direction, coping with change, and coping with uncertainty by formulating future courses of action. The following standards are designed to assist in developing an organization's planning capability. This section addresses planning in relation to governance, marketing, and health and safety.

### **Governance:**

- GOV.1** The agency has governing body bylaws or policies and procedures that reflect how governing body members are recruited and oriented.
- GOV.2** The agency has a written mission statement that describes the purpose of the organization and the shared values of the organization's members.
- GOV.3** The governing body acts to assure that the agency's operation and management practices are consistent with the purpose and shared values in the mission statement.
- GOV.4** The governing body and its committees should meet with a frequency sufficient to carry out their responsibilities effectively.

#### **Interpretive Guideline for GOV.3**

Compliance is evaluated using a variety of methods. These methods include, but are not necessarily limited to the following: staff and client interviews, policy, procedure, and meeting minutes review, and compliance with these standards or those established by the agency. Compliance with this standard, to some degree, must be based on surveyor judgment. Since the quality of services is ultimately the responsibility of the governing body, a preponderance of evidence suggesting inadequate attention or support by the governing body may result in a citation of non-compliance.

- GOV.4.A.** All governing body responsibilities set forth in these standards are met, or the failure to meet governing body standards is not due to an insufficient number of meetings.
- GOV.4.B.** The governing body meetings and actions are documented in written minutes.
- GOV.5** The governing body documents its role, responsibilities and duties in the governance of the agency and its relationship to the management of the agency.
- GOV.6** The governing body or a designee shall provide notification in writing to the Division of any major program changes.

#### **Interpretive Guideline for GOV.6**

Major program changes include, but are not necessarily limited to the following:

1. the addition of new services or deletion of existing services;
2. serving a population not served by the agency previously;
3. significant increases or decreases in service capacity as defined by the governing body;
4. significant changes in the organizational structure as defined by the governing body;
5. changes in the executive director, name or ownership of the agency;  
or
6. relocation of services.

GOV.6.A Except under extraordinary circumstances, the governing body will notify the Division at least 30 days before the implementation of any major program change to determine whether any change in licensing status is necessary.

**GOV.7 The governing body shall appoint an executive director responsible for the overall operation of the agency.**

GOV.7.A. The agency has an executive director whose job description reflects responsibility for overall operation of the agency.

GOV.7.B. The organizational chart indicates a sole directorship.

**GOV.8 The executive director meets minimum qualifications for his/her position.**

GOV.8.A. The agency has a job description for the executive director position that includes minimum qualifications.

GOV.8.B. The executive director's personnel file has documented evidence that he/she meets the minimum professional criteria.

**GOV.9 The governing body has a mechanism for obtaining clients' input regarding the agency's services.**

GOV.9.A. *The agency's governing body has client membership or complies with GOV.9.B.*

GOV.9.B. *The agency has a mechanism for obtaining feedback from clients, family members, and*

guardians that includes a procedure for direct input to the governing body.

GOV.9.B.1 The governing body minutes reflect consideration of the recommendations from the agency's client feedback process.

GOV.10 The agency has a policy and procedure regarding conflict of interest that minimally addresses the definition of conflict of interest and the procedures for resolving these issues.

GOV.11 The governing body shall insure that each agency and program is in compliance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and the Maine Human Rights Act (MHRA).

GOV.11.A. There are no substantiated complaints of violations of the ADA, MHRA or Section 504, including instances of lack of handicapped accessibility. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

GOV.11.A.1. All agencies must notify the Division of complaints pursuant to the above cited laws resulting in a reasonable grounds finding by an external regulatory body (MHRC/EEOC).

GOV.11.B. The agency has a policy and procedure regarding compliance with the ADA, MHRA and Section 504, including how persons with disabilities may access services.

GOV.11.C. All existing buildings will receive approval from BDS's Affirmative Action Officer for compliance with the ADA and Section 504.

GOV.11.D. All plans for new buildings or renovation of existing buildings receive approval from the State Fire Marshal's office or designee for compliance with the ADA and Section 504.

#### **Strategic Planning:**

SP.1 The agency has a documented planning process for mental health services based on a periodic analysis of the needs of current and potential clients.

#### **Marketing:**

MRK.1 The agency accurately portrays the scope of their licensed mental health services in audio, visual, or printed material by including only those services provided by the agency.

MRK.2 The agency has evidence that its services are publicized.

MRK.2.A. There is evidence that public information activities have been implemented.

#### **Health and Safety:**

**HS.1            The agency complies with all applicable health codes.**

HS.1.A.        There are no substantiated health code violations.

**HS.2            Any agency not using a public water and/or sewer system shall be inspected and approved by the process outlined by the Department of Human Services.**

HS.2.A.        Any agency without a public water and/or sewer system shall be able to produce a Sanitary Survey report from the approved process of the Health Engineering Division of the Department of Human Services.

HS.2.B.        Any agency without public water and/or sewer system will have Sanitary Surveys conducted as often as required by the Department of Human Services Health Engineering Division regulation.

**HS.3            The agency has policies and procedures for managing and controlling infections.**

HS.3.A.        The agency has documented evidence that they have implemented policies and procedures regarding the management and control of infections.

**Interpretive Guideline for HS.3 and HS.3.A**

The management and control of infections has become one of the most serious issues for society, in general, to address. The management staff should determine the extent to which their agency, clients, employees, and others are at risk for acquiring and transmitting infections. Based on this determination, the agency should develop and implement reasonable policies and procedures to manage and control the potential for acquiring or transmitting infections. For example, an inpatient service that commonly treats IV drug users would be expected to have more extensive mechanisms in place for preventing and controlling infections than an outpatient clinic.

**HS.4            Agencies shall be inspected by the State Fire Marshal or the Fire Marshal's designee to assure compliance with the NFPA 101 Life Safety Code (current edition).**

HS.4.A.        Residential facilities have verification of annual fire inspections from the State Fire Marshal or Fire Marshal's designee assuring compliance with NFPA 101 Life Safety Code and safe occupancy.

HS.4.B.        Non-residential programs have biennial letters from the State Fire Marshal or the Fire Marshal's designee assuring compliance with NFPA 101 Life Safety Code and safe occupancy.

**HS.5            Quarterly fire drills are conducted and documented for non-residential services and monthly for residential services per NFPA 101 Life Safety Code (current edition).**

HS.5.A.        There is documented evidence that the agency is

in compliance with fire drill requirements.

**Interpretive Guideline for HS.4 through HS.5**

Consult the current edition of the NFPA 101 Life Safety Code for requirements in each type of occupancy.

**HS.6            The agency has a written disaster and evacuation plan specifying procedures for personnel and designating specific tasks and responsibilities.**

HS.6.A.        The agency disaster plan addresses a variety of pertinent disasters, e.g., fires, power outages, storms.

HS.6.B.        The disaster plan addresses staff preparedness, including staff requirements and the designation of roles and functions, particularly in terms of capabilities and limitations.

**HS.7            There is documented evidence that staff members receive initial and continuing education concerning disaster and evacuation procedures.**

**Organizing**

Organizing is the manner in which an agency structures itself to accomplish work. It includes establishing lines of authority; specifying work and reporting responsibilities; job design and methods; and coordination, information and feedback systems. This section includes standards on organizational structure, client records, management information systems, and physical plant management.

**Organizational Structure:**

**OS.1            There is a written table of organization that accurately depicts the organization and lines of responsibility for each budgeted position by program category or service type.**

**Client Records:**

**REC.1 The agency shall maintain client records in a manner that provides security.**

REC.1.A.        Client records are stored in secure areas such as locked file cabinets.

REC.1.B.        Automated record keeping systems have restricted access through access codes or other automated security measures.

REC.1.B.1      There is a back-up system for all automated client records.

REC.1.C.        The agency has a policy and procedure regarding personnel who are authorized to have access to records that is in compliance with federal, state and local laws.

REC.1.D.        There is a method for documenting when records

are accessed and taken from the area where they are stored (i.e., outguides, logs). This method should minimally document the person's name, title or relation to the client, date and time taken and returned.

REC.1.E. There are no substantiated complaints of breaches of confidentiality that result from improper records management. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**REC.2 Client records shall contain identifying information sufficient to describe the client's background, resources, and need for treatment.**

REC.2.A. Records should minimally contain the following information about the client:

- REC.2.A.1 full name;
- REC.2.A.2 address;
- REC.2.A.3 phone number(s);
- REC.2.A.4 date of birth;
- REC.2.A.5 gender;
- REC.2.A.6 unique client identifier;
- REC.2.A.7 income and financial resources;
- REC.2.A.8 next of kin or other contact person;
- REC.2.A.9 occupation;
- REC.2.A.10 current school and grade level or highest level achieved;
- REC.2.A.11 family composition;
- REC.2.A.12 marital status
- REC.2.A.13 living arrangement outside the agency, if applicable;
- REC.2.A.14 prescription and over-the-counter medications used previously and currently;
- REC.2.A.15 allergies and drug reactions.

**Interpretive Guideline for REC.2.A. through REC.2.A.15**

Emergency services shall provide documentation of as many of the above elements as possible.

REC.2.B When the client is a minor or ward, the record should also include: the name, address and phone number of the legally responsible parent, guardian or custodian.

**REC.3 All documents or entries in the client record shall be legible, dated and signed by the person making the entry, written in ink or typed, and properly corrected as necessary.**

**Interpretive Guideline for REC.3**

"Properly corrected" is interpreted to mean that errors are voided by crossing out the incorrect entry with one line, writing "void" next to the crossed out entry, and initialing and dating the correction. Although writing "error" is acceptable, most attorneys/risk managers suggest that agencies avoid writing "error" in client records. White out shall not be used to correct errors in client records. Signature stamps are only allowed for individuals with handicapping conditions and when a written agency policy and procedure on the use of signature stamps is present.

**REC.4 The agency has a documented internal record review process that periodically determines and improves compliance with these standards and other policies and procedures the agency may develop.**

**Management Information Systems:**

**MIS.1 Agencies providing services to AMHI class members will supply data to the Department necessary to meet the Department's obligations under the AMHI Consent Decree.**

MIS.1.A. The agency cooperates in the State's licensing, contract review and quality assurance activities.

**MIS.2 There is documented evidence of the client or legal representative's informed consent of releasing data outside the agency except when such release is allowed by law.**

MIS.2.A. The agency will not breach client and family confidentiality through data distribution or denial of services due to the refusal of the client to release data. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**MIS.3 The agency has a policy and procedure establishing practices that protect the confidentiality of clients when using cellular phones, facsimile machines, automated information systems and/or other technologies that can be used to store, analyze or transmit information.**

**MIS.4 The agency has a policy and procedure for granting client, and/or legally responsible party, access to information and/or data maintained internally or transmitted externally that is specific to that particular client.**

**Physical Plant Management:**

**PHY.1 Agencies assure the personal health, safety, dignity and privacy of clients and strive for provision of services in surroundings in keeping with the needs of the client population.**

PHY.1.A. The agency complies with all Rights of

Recipients regulations concerning health, safety, dignity and privacy.

PHY.1.B. The agency will not violate health, safety, physical plant or client rights regulations.

**PHY.2 All grounds, space, equipment, and physical plant shall be in good repair and provisions shall be made, either through staff or contracts, to maintain the facilities.**

PHY.2.A. The grounds, space, equipment, and physical plant are in good repair upon inspection.

PHY.2.B. There is documented evidence, through staff job descriptions, policies and procedures, or contracts, that both routine and emergency physical plant needs are maintained.

PHY.2.C. Maintenance and repairs are done according to federal, state, and local safety codes.

**PHY.3 The agency assures that all client areas within their organization are provided with appropriate furnishings.**

PHY.3.A. Furnishings are appropriate to the ages and physical condition of the clients.

PHY.3.B. Furnishings are structurally designed and maintained to promote a comfortable and safe environment.

PHY.3.C. Furnishings are available and conducive to their purpose and function.

PHY.3.D. Furnishings are clean and in good repair.

**PHY.4 The agency assures that staff-client, staff-family, and client case communications are conducted in a confidential manner and environment.**

**Interpretive Guideline for PHY.4**

Staff-client communications and/or client case discussions are conducted in an area that assures confidentiality (a separated space or a sound-masked area).

PHY.4.A. There are no substantiated cases of breaching client confidentiality.

**Staffing**

Staffing as used in this context is another word for human resource management. It describes a wide range of activities, programs and policies related to acquisition and retention of human resources. This section includes standards on human resource management and volunteers and students.

**Human Resource Management:**

**HRM.1 The agency has written documentation that each person's duties, responsibilities and performance expectations are clearly communicated upon hire.**

**HRM.2 Staff members meet minimum qualifications for their job as cited in**

**their job description.**

HRM.2.A. Each position in the organization has a job description that minimally contains the:

HRM.2.A.1 title;

HRM.2.A.2 supervisor;

HRM.2.A.3 supervisees;

HRM.2.A.4 duties and responsibilities; and

HRM.2.A.5 minimum education, training and experience qualifications

**HRM.3 The agency has a policy and procedure that addresses the mechanism by which all employees have access to, or receive a copy of, the personnel policies and procedures.**

HRM.3.A. The agency documents that each employee has reviewed or received a copy of the personnel policies and procedures by way of signature in the employee's personnel file.

**Interpretive Guideline for HRM.3.A**

Documentation may include a form indicating the employee has reviewed policies/procedures, the distribution of personnel policy handbooks, etc.

**HRM.4 The agency has policies and procedures for the recruitment, selection, and retention and promotion of employees, volunteers, and students.**

**HRM.5 The agency has a policy and procedure establishing practices for the termination or temporary layoff of employees, including provision for notification of the employee and mechanisms for appeal.**

**HRM.6 The agency has a policy and procedure concerning employee grievances that includes notifying employees of the procedure and maintaining confidential communications and records.**

**HRM.7 Each employee, student and volunteer has a personnel record.**

HRM.7.A. The agency has a policy and procedure concerning maintaining personnel records for each employee, student or volunteer.

HRM.7.B. Personnel records should be maintained similarly and contain documentation pertinent to the employee's, student's or volunteer's work, supervision and training.

**HRM.8 Each personnel file contains information documenting and verifying the positions held by the employee, volunteer or student and their qualifications and experience.**

HRM.8.A. Each employee, volunteer, or student's personnel record minimally contains the following:

HRM.8.A.1 job description;

HRM.8.A.2 copies of appropriate licenses and certifications;

HRM.8.A.2.a this will include either licensure as a mental health professional in the state of Maine, certification by the Bureau of Mental Health or Bureau of Children with Special Needs as an Other Quality Mental Health Professional, or certification by the HRD program as an MHRT;

HRM.8.A.3 copies of diplomas, transcripts or documentation of verbal verification from the school officials citing date and school official contacted;

HRM.8.A.4 records of continuing education and training

***Interpretive Guideline for HRM.8.A.4***

Continuing education or training records may be in the form of certificates noting date, title of training, number of hours or CEU's or other listings of training received with content, date, presenter and length of training documented. Although documenting all training in the personnel record is preferred, documentation of training received within the organization may be kept in alternative records, e.g., training log.

HRM.8.A.5 documentation, before start date, regarding the individual's criminal/abuse history (e.g., checking with SBI, DHS).

HRM.8.A.5.a If checks with SBI or DHS produce information regarding an employee, the agency will document in the personnel file its assessment of the seriousness of the information provided and take appropriate actions if indicated.

***HRM.9 An individual's need for training and continuing education is assessed with the individual's participation and documented within 6 months of hire or job change and at least annually thereafter.***

***HRM.10 All employees, students and volunteers are given a copy of the Rights of Recipients (Adult and/or Children as appropriate).***

HRM.10.A There is documented evidence that all employees, students and volunteers review the Rights of Recipients (Adult and/or Children's editions) before commencing the duties of their job and when there is a change in the Rights regulations.

#### **Interpretive Guideline for HRM.10.A**

Documented evidence may be a statement or other documentation, signed and dated by the employee, student or volunteer that confirms that they have reviewed the Rights of Recipients (Adult and/or Children's editions).

**HRM.11      The agency has policies and procedures on access to personnel files that minimally include: the employee's right to access, protection of confidential information, secure storage, making record entries, and distribution of information upon staff request.**

HRM.11.A.    The agency has policies and procedures that minimally address the following personnel records issues:

HRM.11.A.1   who in addition to the employee, has access to personnel records;

HRM.11.A.2   how confidential personnel information is protected;

HRM.11.A.3   how personnel records are securely stored;

HRM.11.A.4   who in addition to the employee may enter information into the personnel records; and

HRM.11.A.5   how and to whom information from personnel records may be disseminated.

**HRM.12      The agency has a policy and procedure that addresses when a personnel record is considered inactive and what practices are followed in its disposal to assure the employee's confidentiality.**

**HRM.13      The agency has documented processes for addressing employee issues, including policies and procedures on employee recognition, supervision and discipline.**

**HRM.14      The agency is an Equal Opportunity Employer.**

HRM.14.A.    The governing body establishes and adheres to policies and procedures that provide for periodic review and approval of the personnel policies for compliance with federal, state and local laws.

#### **Interpretive Guideline for HRM.14.A**

The definition of "periodic review" is determined by the governing body and is the basis upon which compliance will be determined by licensing staff. Failure to define periodic review will result in a citation for this standard.

HRM.14.B.    There are no substantiated cases where an agency fails to follow personnel policies and procedures as required by federal, state or local laws.

HRM.14.C    All agencies must notify the Division of discrimination complaints resulting in a reasonable grounds finding by an external regulatory body (MHRC/EEOC).

HRM.14.D.    The agency has received approval from the

Department's Affirmative Action Officer as an Equal Opportunity Employer.

**HRM.15**      **Each employee's job performance shall be evaluated on at least an annual basis based upon performance criteria established for the position.**

HRM.15.A.    Each employee's personnel files shall contain a copy of that employee's performance evaluation.

**Volunteers and Students:**

**VS.1**          **Individuals who work as volunteers for the agency or who are students shall be clearly identified by title as volunteers or students.**

**VS.2**          **Student supervision shall include documenting in their personnel record contact with the person at the school who is supervising the student's educational progress.**

**Interpretive Guideline for VS.2**

If the school does not designate a liaison, documentation of this should be placed in the student's personnel record.

**VS.3**          **Students or volunteers are supervised by individuals with licensure, certification, or experience in an area germane to the work assigned.**

**Directing**

Directing is a management function that attempts to facilitate or initiate action within an agency. Activities of directing generally involve interpersonal aspects of management such as motivation, leading, communicating, conflict resolution, and change management. This section includes standards on staff development and supervision.

**Staff Development:**

**SD.1**          **The agency has an orientation program that is in place for all new employees that assures that each new employee receives specific information relevant to their duties and the organization.**

SD.1.A.      The agency has an orientation program for new employees that minimally provides training in the following areas:

SD.1.A.1     the Rights of Recipients (Adult and/or Children's current editions);

SD.1.A.2     the identification, response and reporting of abuse, neglect, and exploitation;

SD.1.A.3     the employee's specific job responsibilities;

SD.1.A.4     the agency's mission, philosophy, clinical and other mental health services;

- SD.1.A.5 the agency's service and therapeutic modalities designed to facilitate health, growth, and recovery;
- SD.1.A.6 the client and family's right to privacy and confidentiality;
- SD.1.A.7 the physical intervention techniques used, if applicable;

**Interpretive Guideline for SD.1.A.7**

The determination of the need for training in physical intervention techniques shall be based upon a documented assessment of client's potential for and history of assaultiveness. Agencies that do not provide training in physical intervention techniques must be able to document compelling evidence that physical intervention training is unnecessary.

- SD.1.A.8 safety/emergency procedures;
- SD.1.A.9 infection control and prevention;
- SD.1.A.10 the terms of the AMHI Consent Decree, as applicable;
- SD.1.A.11 the perspectives and values of clients of mental health services conducted by a consumer of mental health services.

**Interpretive Guideline for SD.1.A.11**

For children service agencies, the perspectives and values of families are addressed. Children service agencies may also have a family member provide this orientation.

- SD.1.A.12 the individual community support planning process, if applicable;
- SD.1.A.13 the mental health service system;
- SD.1.A.14 the family support services;
- SD.1.A.15 the role state and private psychiatric hospitals play in relation to the agency;
- SD.1.A.16 adverse reactions to psychoactive medications, if applicable;
- SD.1.A.17 child development and children's educational needs for staff who work with children and/or adolescents;
- SD.1.A.18 for staff working with individuals over the age of 60, psychogeriatrics and communication techniques with elderly persons; and
- SD.1.A.19 training in the inter-relationship of co-occurring conditions and referral and treatment processes for staff members who work with individuals with co-occurring conditions.

SD.1.B. Each staff member completes orientation within 60 days of hire.

**Interpretive Guideline for SD.1.B**

Allowances will be made for individuals receiving Mental Health Rehabilitation Technician training I through IV.

SD.1.C. New employees shall not be assigned to duties requiring direct involvement with clients until the italicized topics above have been completed.

**SD.2            The agency plans for and provides ongoing training and technical assistance to improve staff performance.**

SD.2.A. There is an agency staff development plan formulated annually which highlights areas for training on issues pertinent to the service(s) offered by the agency.

SD.2.B. There is documented evidence that ongoing training and continuing education is conducted and is based on areas assessed in HRM.9.

**SD.3            There is documented evidence that mental health staff employed 20 or more hours a week participate in at least 20 hours of training annually and/or maintain the number of training hours required by their licensure, whichever is greater.**

**SD.4            There is documented evidence that mental health staff employed fewer than 20 hours per week minimally receive annual training in the following areas:**

SD.4.A. the results of the assessment required in HRM.9; and

SD.4.B. the new agency policies and practices pertinent to the individual's role.

**Supervision**

**SUP.1    The agency has evidence that it provides administrative supervision to each employee, student and volunteer.**

**SUP.2    The agency has written policies and procedures on the provision of clinical supervision or consultation to each individual with clinical responsibilities.**

**Interpretive Guideline for SUP.2**

Minimum supervision/consultation requirements are one hour consultation per month for those licensed to practice independently and 4 hours per month for practitioners not licensed to practice independently or the amount of supervision required by their professional licensing authority (whichever is greater). For independent practitioners consultation can include case reviews and team meetings in which the individual is not acting in a supervisory capacity.

**SUP.3    Clinical supervisors are trained to provide supervision as evidenced by documentation of supervision training and licensure or certification germane to the supervision of the service provided.**

**Controlling**

Controlling is the management function that measures, monitors, and regulates the agency's activities and resources. These activities are usually based on established standards for measuring results as well as methods for taking corrective action or instituting improvements. This section includes standards on quality, risk, utilization, financial, and contract management.

### **Quality Management**

Quality management is broadly defined as management philosophies and behavioral and statistical tools aimed at improving quality, customer satisfaction, and profitability. Although all effective quality management processes have distinct similarities, each agency must adopt quality management principles and practices that are sensitive to their organizational culture and effective in their particular setting. For this reason, the Department and the Division of Licensing does not espouse one particular model of quality management. Therefore, the first four standards in this section relate to an agency's ability to demonstrate that they have an ongoing and effective quality management process that is customer-focused and strives for customer satisfaction.

- QM.1            The agency has a written plan that addresses how the organization currently monitors, evaluates and improves quality.**
- QM.2            The agency can demonstrate that it identifies, monitors, and attempts to improve areas deemed to be critical to quality client care.**
- QM.3            There is documented evidence that quality management activities are conducted on an ongoing and regular basis.**
- QM.4            The effectiveness of quality management is assessed and documented at least annually and involves input from clients, family members, guardians, client representatives, staff, and referral sources.**
- QM.5            The agency shall have, available for review, insurance policies citing professional and commercial liability coverage for the organization, staff, volunteers, and students.**
- QM.6            The agency has a policy and procedure regarding the reporting and recording of adverse and potentially adverse occurrences, including the recording of complaints.**
  - QM.6.A.Reports of adverse and potentially adverse occurrences will be evaluated for the need for follow-up actions and opportunities for improvements in agency management and/or service delivery.
  - QM.6.A.1            In such instances, follow-up actions will be documented.
  - QM.6.A.2            The agency shall have a policy and procedure for reporting allegations of abuse, neglect and exploitation of clients in accordance with the requirements of the Adult and Child Protection laws.

#### **Interpretive Guideline for QM.6**

Some examples of adverse or potentially adverse occurrences include, but are not necessarily limited to:

1. deaths;
2. injuries;
3. violations of agency policies; and
4. violations of client rights.

**QM.7 Each agency has a process for monitoring and evaluating the appropriateness of admission to or initiation of service and the provision of continued service to the client, based on admission and continued service criteria.**

QM.7.A. The agency has admission or service initiation criteria and continued service criteria that are used in reviewing each case upon admission or initiation of service and regularly thereafter to assure the delivery of services/care in a least restrictive environment.

QM.7.B. Individuals are not inappropriately admitted or served in an agency, service or setting.

**QM.8 The agency has a process for documenting clients' needs and determining how well the organization's services meet those needs.**

**QM.9 The agency shall report immediately to the Division any legal proceedings arising out of circumstances related to providing mental health services.**

#### **Interpretive Guideline for QM.9**

Agencies must immediately provide a verbal report to the Division once the agency is legally served notice of legal proceedings. Written notice must be received within 3 working days following receipt of verbal reports. Some examples of legal proceedings that should be reported include, but are not necessarily limited to the following:

1. bankruptcy;
2. professional licensing body sanctions;
3. discrimination;
4. lawsuits; and
5. criminal activity by a staff member(s) that has implications for the programmatic and/or fiscal integrity of the agency and the safety of its clients.

**QM.10 The agency shall post the original current license issued by the Department in a clearly visible place within the central facility and copies in all branch locations.**

**Interpretive Guideline for QM.10**

Residential facilities may post the license in an office area of the residence or similar inconspicuous location.

**QM.11 The agency can demonstrate compliance with all client rights regulations as stated in the current edition of the Rights of Recipients (Adult and/or Children's Services editions).**

- QM.11.A. The agency will have a policy and procedure establishing the means by which compliance with the Rights of Recipients will be achieved.
- QM.11.B. All substantiated complaints of violations of the Rights of Recipients will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**Financial Management:**

**FM.1 The governing body is responsible for insuring the establishment and maintenance of sound fiscal practices as evidenced by the development and periodic review of policies regarding the fiscal practices of the agency.**

- FM.1.A. The governing body reviews the financial status of the agency on a periodic basis, and minimally reviews the agency's annual audit and approves the annual budget.

**Interpretive Guideline for FM.1 and FM.1.A**

"Periodic" is to be defined by the governing body. The organization will be evaluated on:

1. the existence of fiscal policies and procedures;
2. compliance with the governing body's requirements for policy development and periodic policy review; and
3. the minimum review and approval activities cited in FM.1.A.

**FM.2 Where fees are charged, a schedule of fees for services and policies concerning collection of fees shall be made available to each client or their legally responsible party or posted in the facility for public view.**

- FM.2.A. There is a documented fee schedule.
- FM.2.B. When the fee schedule is not posted for public view, there is documented evidence that clients and/or the legally responsible party have received notification of the fee schedule.

**FM.3 Agencies will have documented annual audits from an independent certified public accountant verifying that generally accepted accounting practices are being maintained.**

**Interpretive Guideline for FM.3**

The agency must contact the Division for written approval of alternative auditing mechanisms.

**Contract Management:**

- CM.1            Agencies that have a contract with a bureau of the Department of Mental Health and Mental Retardation must be in compliance with this contract as measured by the contracting bureau.**

**CLINICAL MANAGEMENT**

This section of the core standards addresses the clinical management processes deemed to be critical in providing care or services to the client.

**Access**

- AC.1            Each agency facility shall have in effect a transportation plan that assures accessibility to services.**
- AC.1.A. The agency documents and takes steps to implement a transportation plan that is directed toward assuring reasonable accessibility to all services.
- AC.2            Service hours of the agency and the means for accessing services outside of normal business hours are clearly defined at each service site and in literature distributed to the public.**

### **Interpretive Guideline for AC.2**

"Normal business hours" are interpreted to mean Monday through Friday for an 8 hour period some time between the hours of 8:00am and 5:00pm. Agencies that do not provide access to services outside of normal business hours must be able to produce compelling evidence as to why these service hours are not necessary or possible. Agencies that do not provide access to services outside of normal business hours must be able to produce compelling evidence as to why these service hours are not necessary or possible.

AC.2.A. All substantiated complaints regarding accessibility to services will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**AC.3                    The agency has a mechanism for providing services in the language chosen by the applicant or client.**

AC.3.A. Services will be made available to all potential clients in their language of preference. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**AC.4                    No individual may be denied access to services solely on the basis of having a known substance use/abuse disorder in addition to his/her mental illness.**

AC.4.A. The agency shall develop and maintain a written protocol or policy that describes its service approach to individuals with co-occurring mental illness and substance abuse disorders.

**AC.5                    Agencies shall insure that clients are not denied access to services based solely upon the clients' refusal of any other service.**

### **Client Rights**

**CR.1                    At the request of the client, or the legally responsible party, the agency will arrange for a second opinion to be offered by another practitioner from within the agency, who is mutually agreed upon by the client or legally responsible party and the agency.**

CR.1.A. The agency has a documented policy and procedure describing the process for seeking second opinions that minimally addresses who notifies the client of this right and who documents the request and actions taken in the client record.

CR.1.B Second opinion requests and actions the agency takes as a result are documented in the client's record. Second opinion record entries minimally include:

CR.1.B.1                    the date of the request;

CR.1.B.2                    the reason for the request;

CR.1.B.3                    the actions taken by the agency as a result of the request.

CR.1.C. The practitioner(s) offering the second opinion document in the client record the date they conducted their assessment, their findings, conclusions, and recommendations.

#### **Interpretive Guideline for CR.1.C**

It is expected that the practitioner(s) offering the second opinion will minimally see the client in person and review their record.

**CR.2** When a client or legally responsible party requests and agrees to pay the cost of a second opinion, the agency does not impede the right to seek a second opinion from a practitioner of his/her choice and does not terminate the client solely because of seeking this second opinion.

CR.2.A. An agency will not impede the right of or terminate services to clients seeking a second opinion. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**CR.4** Only staff who have completed training in physical intervention shall implement physical intervention techniques.

#### **Treatment and Care Processes**

##### **Preliminary Screening:**

**SCR.1** The agency determines an applicant's eligibility for services through a timely preliminary screening process that assesses the applicant's appropriateness for services based on the service's admission or intake criteria.

SCR.1.A. An eligibility screening is conducted and documented for each applicant.

SCR.1.B. The documented screening contains a determination of the applicant's appropriateness for services.

SCR.1.C. Eligibility criteria and screening processes for all programs and services will be in compliance with the requirements of GOV.11.

#### **Interpretive Guideline for SCR.1**

Preliminary screenings will not trigger the time-limited documentation requirements, e.g., assessment, service plan, that begin with initiation of service, unless otherwise required by agency policy.

**SCR.2** The agency has documented admission or intake policies and procedures that assure thorough evaluation of each applicant's eligibility.

SCR.2.A. There are documented policies and procedures for routine or non-emergency admissions or intakes that minimally include:

SCR.2.A.1 the procedures for accepting referrals from outside agencies;

SCR.2.A.2 the information to be obtained on all applicants or referrals for admission or receipt of service;

SCR.2.A.3 the records to be kept on all applicants and for what length of time the records are kept;

SCR.2.A.4 the statistical data to be kept on the intake process;

- SCR.2.A.5 the procedures to be followed, including alternative referrals, when an applicant is found ineligible or inappropriate for admission or services; and
- SCR.2.A.6 the procedure for aggregating and analyzing collected data for use in the agency planning process.

**SCR.3 The agency has documented policies and procedures for handling emergency intakes or admissions.**

**Interpretive Guideline for SCR.3**

Agencies or services that do not accept emergency intakes will have a policy stating the justification for refusal of emergency intakes or admissions.

**Assessments:**

**AS.1 Assessments are conducted by qualified staff.**

**Interpretive Guideline for AS.1**

This standard is surveyed following review of the service specific assessment standards. That is, "qualified" is determined by the degree of compliance with assessment standards rather than on other qualifications, e.g., degrees or certifications.

**Progress Notes:**

**PN.1 Progress notes are current and address progress towards service plan goals as well as other interactions that may be pertinent to the service needs of the client.**

PN.1.A. Progress notes are written at least weekly unless services are designed to be offered less frequently.

PN.1.A.1 For services that are provided on such an intermittent or infrequent basis to make weekly notes inappropriate, the agency shall develop a policy and procedure concerning the frequency with which notes should be written.

PN.1.B. For services provided on an intensive basis, the agency shall develop policies and procedures establishing a frequency of documentation sufficient to reflect the intensity of service delivery.

**Discharge Planning and Transfers:**

**DPT.1 The agency shall develop and implement a discharge plan consistent with the needs and goals of the client.**

DPT.1.A. Upon review, the discharge plan is consistent with the needs and goals identified in the service plan.

DPT.1.B. Clients are discharged in a manner and to a setting consistent with their discharge plan.

DPT.1.C. Clinical justification is documented when referring a client to an

alternative setting.

DPT.1.D. Discharge planning in residential settings will be conducted in compliance with the requirements of standards RS.11 through RS.16.

**DPT.2 When discharge planning indicates the need for residential services, the agency shall provide clients with information about residential options sufficient for clients to make informed choices.**

**DPT.3 Upon the client's or legally responsible party's documented informed consent, the agency transferring or discharging the client will provide a written transfer or discharge summary to the receiving agency.**

**DPT.4 The agency transferring a client to another service within the organization or to an outside service provider assures that the transfer is completed in a manner that protects the client's safety, comfort, and dignity.**

DPT.4.A. All transfers of clients will be accomplished in a manner that assures the client's safety, comfort, or dignity. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

#### **Continuity of Care:**

**CC.1 When an agency offers services through another provider, a documented affiliated service agreement exists.**

**CC.2 The agency has a policy and procedure that identifies how service components of their agency and other providers work collaboratively in planning and providing services that are sensitive to client's transition needs.**

CC.2.A. All substantiated complaints regarding transition from one service to another will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**CC.3 Clients are referred to contracted service providers only after a determination of need has been documented in the client's service plan.**

**CC.4 The agency has a policy and procedure concerning the delivery or referral to family support groups, which minimally contains how the determination for family support is made and how delivery or referral is accomplished.**

#### **Medications:**

**MED.1 Where medications are available administered, or supervised by staff in the agency, the agency shall retain and securely store medications.**

MED.1.A. Medications are kept in original containers in a locked storage cabinet.

MED.1.B. The storage cabinet shall be equipped with separate cubicles, plainly labeled, and locked when not in use.

MED.1.C. Medications marked "for external use only" shall be stored separate from other medications.

MED.1.D. Refrigerated medications shall be kept separate from food by placing

them in special trays or containers.

**MED.2 Where clients self-administer medications, the agency shall provide to clients the capacity for secure storage.**

MED.2.A. Clients that self-administer medications shall be allowed to keep such medications in a locked storage container in their private living areas.

MED.2.B. No client shall maintain a private drug supply for which there are no physician's orders or prescription label with the client's name.

**MED.3 Agencies retain a professionally qualified individual to provide education and supervision when agency clients self-administer medications and agency staff monitor compliance and observe for side effects.**

MED.3.A. Unlicensed personnel shall be trained to observe for side effects and drug reactions to psychotropics and frequently used medications (such as antibiotics) by a registered nurse consultant, and/or physician, and/or pharmacist.

MED.3.B. There shall be documentation of the activities of the professionally qualified individual including staff training and review of client records/logs.

**MED.4 Where medications are available, administered or supervised by staff in the agency, the agency shall have a procedure for prescribing.**

MED.4.A. Written orders to administer/discontinue medications are generated by a physician, dentist, or physician extender.

MED.4.B. Physicians review medications at least every 30 days in inpatient settings, every 90 days in outpatient settings and, in residential settings, psychotropic medications will be renewed every 90 days and all other medications no less frequently than one year.

MED.4.C. Telephone orders are accepted by a registered nurse or pharmacist, and only when necessary because of emergency circumstances.

MED.4.D. Written dated orders taken by agency staff must be signed by the physician within 24 hours.

**MED.5 Where medications are available, administered, or supervised by staff in the agency, there is a policy regarding their administration.**

MED.5.A. The agency has policies regarding medication administration that take into account the client's right to privacy and dignity.

**MED.6 No medication is prescribed and administered without the written informed consent of the client or legally responsible party.**

MED.6.A. There is a process by which the prescribing physician informs the client and/or legally responsible party, and when appropriate, the community support worker, of the potential effects and side effects of medications they prescribe, e.g., information sheets.

**MED.7 Where medications are available, administered, or supervised by staff in the agency, there is a policy regarding inventory of medications and paraphernalia.**

MED.7.A. There is documentation that controlled drugs are counted by the incoming and outgoing medication personnel at the change of each shift.

**MED.8 Where medications are available, administered, or supervised by staff in the agency, there is a policy regarding reporting and disposing of outdated medications.**

MED.8.A. There is documented monitoring for outdated medications at least quarterly.

MED.8.A.1 This monitoring shall include documentation of where the outdated drugs are sent and whether they were disposed of according to applicable federal, state and local laws.

**MED.9 Where medication is prescribed, administered, or supervised by staff in the agency, a medication record and a record of each occasion of medication administration shall be maintained.**

MED.9.A. A medication record shall be maintained which minimally includes:

MED.9.A.1 the prescribing physician;

MED.9.A.2 personnel administering the medication;

MED.9.A.3 type and frequency of monitoring for effects of the medication.

MED.9.B. A medication administration record shall be maintained which minimally includes:

MED.9.B.1 the type of medication;

MED.9.B.2 the dosage; and

MED.9.B.3 the frequency of use.

**MED.10 In instances of medication errors, side effects, adverse reactions, client or staff concerns regarding medication, staff inform the prescribing physician and document the problem in an occurrence report.**

**MED.11 When the agency prescribes, administers, or supervises medications, there is a process for monitoring the effectiveness of medications.**

MED.11.A. Staff members with a minimum of a medication technician certification approved by Maine's Department of Human Services, regularly review and document client response to medication.

MED.11.B. Side effects, adverse reactions and client concerns are documented, treated in a timely fashion, and corrected.

**MED.12 When medications are prescribed by agency staff or consultants prescribing as part of the agency program, the prescribing professional is available to discuss medication issues and concerns between appointments.**

MED.12.A. Documented concerns regarding medications are quickly followed by

documented consultation with the prescribing physician.

MED.12.B. There are no substantiated complaints regarding the availability or accessibility of the prescribing physician. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**MED.13 The agency complies with all federal, state and local laws concerning medication administration.**

MED.13.A. There are no substantiated violations of any federal, state or local laws concerning medication administration.

## **SERVICE-SPECIFIC STANDARDS**

In addition to the core standards, which all mental health agencies need to comply with, an agency will also be surveyed according to the services they provide. In this way, an agency is given a tailored survey that reviews the full scope of their services. This manual currently addresses the following services:

Community Support  
Crisis Residential  
Emergency  
Inpatient  
Outpatient  
Residential  
Social Clubs<sup>1</sup>

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<sup>1</sup> Social clubs are the only type of service that are not required to comply with the core standards contained in this manual. Social clubs, due to their unique nature and services, have a separate set of standards used during the licensing process.

## COMMUNITY SUPPORT SERVICE STANDARDS

These standards, in addition to the core standards, are applied to agencies providing community support services for clients with severe and disabling mental illness, and include case management, outreach, assistance in meeting basic needs, direct skill teaching (activities of daily living, social skills, etc.), assistance, consultation, education, advocacy, and supportive counseling. Community support functions include: developing service agreements, participation in hospital discharge meetings, providing personalized support to clients, and participation in crisis intervention and resolution.

### Access

**CS.1                    The agency has policies and procedures governing the establishment of a waiting list which minimally includes the following: prioritizing clients, selecting clients from the waiting list, and referring to other providers.**

**CS.2                    Eligible individuals are informed of their right to receive an Individualized Support Plan and community support services and, when accepted or requested, receive them in a timely fashion.**

CS.2.A. There is documented evidence that clients living in the community who apply and are eligible for services, are assigned a community support worker within three working days of application.

CS.2.A.1              When community support services cannot be assigned within three working days, the agency shall immediately notify the Commissioner in writing.

CS.2.B. There is documented evidence that an Individualized Support Plan is developed within 30 days of application.

CS.2.C. When a hospitalized client requests a community support worker, a worker will be assigned within one working day of receipt of the request from the hospital.

CS.2.C.1              The agency documents the date and time of the hospital's request;

CS.2.C.2              The agency documents the date and time the community support worker was assigned.

CS.2.D. There is documented evidence that individuals who decline the services of a community support worker or Individualized Support Plan are informed that they may apply for these services at any subsequent time.

CS.2.E. The agency will develop a policy and procedure and be able to demonstrate that the screening process for determination of eligibility for services is completed within 30 days of application.

**CS.3                    There are regular and scheduled outreach services available in the agency's service area.**

CS.3.A Outreach contacts are documented and attempt to address the following:

CS.3.A.1              identifying information;

CS.3.A.2              an informal assessment of the individual's needs;

- CS.3.A.3 the individual's level of commitment to initiate services; and
- CS.3.A.4 an informal plan for engaging the individual further.

**Interpretive Guideline for CS.3 through CS.3.A.4**

For outreach services in general, informed consent for service provision should be obtained when an individual agrees to initiate services. Initiation of service is defined as the point when an individual agrees to have an outreach worker actively pursue services, other than information and referral, on their behalf.

**Assessment**

**CS.4 A comprehensive assessment is conducted by an individual chosen or agreed to by the client, with the client's participation, within 30 days of the client agreeing to initiate services.**

CS.4.A. The comprehensive assessment minimally addresses the following:

- CS.4.A.1 the client's strengths and weaknesses;
- CS.4.A.2 the client's perception of his or her needs;
- CS.4.A.3 the family/guardian's input and perception of the client's needs when appropriate, and with the client's consent;
- CS.4.A.4 a personal, family, and social history;
- CS.4.A.5 the emotional, psychiatric and psychological strengths and needs of the client;
- CS.4.A.6 a physical health status and history, including current prescribed and over-the-counter medication use and dental needs;
- CS.4.A.7 past and current drug/alcohol use;
- CS.4.A.8 a developmental history;
- CS.4.A.9 possible sources of assistance and support in meeting the needs expressed by the client or legally responsible party, including state and federal entitlement programs;
- CS.4.A.10 physical and environmental barriers that may impede the client and family's ability to obtain services;
- CS.4.A.11 history of physical and/or sexual abuse;
- CS.4.A.12 the vocational, educational, social, living, leisure/recreation and medical domains; and
- CS.4.A.13 potential need for crisis intervention services;
- CS.4.A.14 housing and financial needs;

CS.4.A.15 the status of the Individualized Support Plan;

CS.4.A.15.a in instances in which the Individualized Support Plan is the only service the client is receiving and there is no evidence of other immediately needed services, the worker will complete a preliminary assessment based upon the information in the workers possession and, every 30 days subsequently, update the status of the ISP in a progress note. For these clients, the comprehensive assessment will be completed within 30 days of the completion of the ISP or the identification of an immediate service need; and

CS.4.A.16 the signature of the person who performed the assessment.

**Interpretive Guideline for CS.4.A.1 thru CS.4.A.16**

The Division of Licensing recognizes that in some cases not all of the information requested in these standards will be able to be obtained. The Division also recognizes that the level of detail required will vary given a variety of factors (the client's level of cooperation, the integrity of information sources, the length of services or treatment, the condition being addressed, the practitioner's training, etc.). Although the Division will attempt to be sensitive to these factors and flexible in surveying this area, the agency should assure that assessments that do not address all these standards have accompanying documentation that justifies abbreviated or absent information.

CS.4.B. The agency will establish and adhere to policies and procedures establishing criteria for the performance of the following assessments:

CS.4.B.1 a nutritional assessment;

CS.4.B.2 a cognitive functioning assessment;

**Interpretive Guideline for CS.4.B.2**

The client's cognitive functioning assessment should include assessment of the following functions: problem solving, decision making, organization, self-direction, system negotiation skills, concentration, and abstract reasoning. For individuals over 60 years of age, this assessment should also include memory, language, orientation, and visuo-spatial abilities.

CS.4.B.3 an assessment of the client's capacity to make reasoned decisions; and

CS.4.B.4 a neurological assessment.

**Interpretive Guideline for CS.4.B thru CS.4.B.4**

These assessments do not necessarily have to be performed in the agency or by agency staff. The intent of these standards are to assure that the agency has mechanisms by which to evaluate the need for these assessments and to perform or refer for assessment those clients whose symptomatology suggests such need.

CS.4.C The assessment(s) shall be obtained from the client, legally responsible party, community service agencies, and to the extent possible, from other individuals in the community as authorized by the client or legally responsible party.

CS.4.D The client record contains a summary evaluation of the data collected in the comprehensive assessment.

**CS.5 The agency has a documented policy and procedure on updating assessments that assures that assessments are current and in no case exceed annual updates.**

### **Service Planning**

**CS.6 There is documented evidence that the service planning and revision process involves the client, legally responsible party, and other representatives and professionals whom the client designates.**

#### **Interpretive Guideline for CS.6**

The client and legally designated guardian shall be fully and actively involved in the development or revision of the service plan, if possible. All individuals designated by the client, including the representative, family members or significant others (so designated by the client) shall be included in the development and revision of the service plan, unless contraindicated. When these individuals do not attend, their absence is noted. Each agency shall document good faith efforts, including at least 10 days notice of any service planning meetings, to involve guardians, representatives or legally responsible parents. In instances in which the agency is unable to provide 10 days notice, a written justification will be entered in the client's record.

**CS.7 A service plan is developed for each client within 30 days of initiation of service, with the client and based upon the wants and needs of the client identified in the comprehensive assessment and, if the client has one, the Individualized Support Plan.**

CS.7.A. The service plan minimally contains the following:

- CS.7.A.1 problem statements;
- CS.7.A.2 short- and long-range goals based upon client needs with a projection of when such goals will be attained;
- CS.7.A.3 objectives stated in terms which allow objective measurement of progress;
- CS.7.A.4 multi-disciplinary input and specification of treatment responsibilities;
- CS.7.A.5 client input and signature;
- CS.7.A.6 signatures of all people participating in the development of the plan;
- CS.7.A.7 the methods and frequency of treatment, rehabilitation, support;
- CS.7.A.8 a description of any physical handicap and any

accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals; and

CS.7.A.9 criteria for discharge.

CS.7.B Justification for not addressing problems identified in the assessments is documented in the client record.

**Interpretive Guideline for CS.7.B**

The intent of this standard is to assure that the clinical staff considers all of the client's identified problems in formulating the service plan. Problems that are not reflected on the service plan should have accompanying documentation identifying the rationale for not addressing the problems at this time. This documentation can take many forms including progress notes, service plan narratives, etc.

**CS.8 The service plan is designed so that the client's progress towards service plan goals can be monitored and evaluated.**

**Interpretive Guideline for CS.8**

Service plans should have measurable goals and some means for reflecting when, or to what degree, a goal has been attained. The organization should also have mechanisms that document monitoring and evaluation of client goals, e.g., quality assessment, treatment plan review documents.

**CS.9 The service plan is reviewed at major decision points in each client's treatment course, upon client request, and no less frequently than every 90 days.**

**Interpretive Guideline for CS.9**

Major decision points may include, but are not necessarily limited to the following: when there is a change in the client's condition, when a service appears not to benefit the client, when the client is under- or over-utilizing services.

**CS.10 Unmet service needs are documented in the service plan and in interim plans subsequent to the service planning process.**

**Interpretive Guideline for CS.10**

If at the time of or subsequent to the service planning meeting, team members know, on the basis of reliable information, that the needed services are unavailable, they shall note them as "unmet service needs" on the service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the client. The organization should also document notification of the organization's leaders and the Commissioner regarding the unavailability of service that is causing the unmet need.

**CS.11 The agency has a policy and procedure for providing clients with a copy of their service plan within one week following its formulation, review or revision and notification of client recourse should they disagree with any aspect of the plan.**

### **Interpretive Guideline for CS.15**

For clients on inactive status, a discharge summary should be completed no later than 90 days following placement on inactive status or earlier given the following conditions:

1. another agency submits a request for the client's discharge summary prior to the 90th day of inactive status;
2. agency policy requires that a discharge summary be completed earlier than the 90th day of inactive status; and
3. practitioners who are leaving agency employment must complete discharge summaries on all of their inactive status clients regardless of time frame.

CS.11.A. There are no instances in which the agency fails to provide a copy of the client's service plan and/or notify them of recourse should they disagree.

### **Service Delivery**

**CS.12 Community support workers assist clients in negotiating linkages with service providers as evidenced by documentation that reflects each contact and the delivery of those services deemed appropriate in the client's service and support plans.**

### **Discharge Planning**

**CS.13 Each client record contains documentation of current discharge or termination planning.**

**CS.14 The agency has discharge planning policies and procedures.**

CS.14.A The agency has a policy and procedure for determining when a client is considered "inactive".

CS.14.A.1 The inactive status policy and procedure notes what documentation is kept on the client during inactive status.

CS.14.A.2 The inactive status policy and procedure notes the duration of inactive status before the case is considered closed.

**CS.15 A discharge summary is entered in the client record within 15 days of discharge or on the 90th day of inactive status and includes the client's course of treatment and ongoing needs at discharge.**

CS.15.A. Each discharge summary minimally addresses, but need not be limited to the following:

CS.15.A.1. the reasons for termination of service;

CS.15.A.2. the final assessment, including the general observations and significant findings of the client's condition initially, while services are being provided and at discharge;

CS.15.A.3. the course and progress of the client with regard to each identified problem; and

CS.15.A.4. the recommendations and arrangements for further continued service needs.

**CS.16 The agency has policies and procedures that specify under what conditions services may be**

**discontinued or interrupted which minimally include how and when the client is notified.**

CS.16.A. For agencies serving DMHMR class members, the agency shall first obtain prior written approval for discontinuing or interrupting services from the Department.

CS.16.B For agencies serving DMHMR class members, the agency shall give thirty days advance written notice to the client and the client's guardian. If the client poses a threat of imminent harm to persons employed or served by the agency, the agency shall give notice that is reasonable under the circumstances.

CS.16.C For agencies serving DMHMR class members, the agency shall give such notice as may be required by law or regulation.

CS.16.D For agencies serving DMHMR class members, the agency shall assist the client in obtaining the services from another agency.

CS.16.E For agencies serving DMHMR class members, the agency shall provide documented evidence in the client record of compliance with these standards, through letters, progress notes, phone logs, and/or facsimile.

**CS.17 Applicants who are not eligible for services will be referred to appropriate services, if required, available and desired.**

CS.17.A. The agency has a policy and procedure on referral and/or transfers of individuals deemed inappropriate for services offered by the agency that minimally includes communicating the rationale for the referral/transfer to the applicant and providing them with a list of alternative service providers and advocacy services.

CS.17.B. The agency provides and documents other assistance as required to assist the individual to obtain/access the services to which they are referring him/her.

## **Health**

**CS.18 If food services are provided, the facilities for the preparation and serving of food shall be inspected and approved by the Department of Human Services.**

CS.18.A. If food is either prepared or served at the facility, then the agency shall either obtain a DHS Eating Establishment license or show written evidence from DHS indicating that they do not need such a license.

CS.18.B. When the agency requires a DHS license, the agency's Eating Establishment license is current.

**CS.19 The agency shall have methods for obtaining on- or off-site medical services for all clients.**

CS.19.A. The agency defines in policy and procedure those medical services delivered on-site. For those medical services not provided on-site, letters of agreement and/or procedures for accessing medical service provider(s) are in effect.

## **Human Resource Management**

**CS.20**            **There is documented evidence that community support workers are licensed or certified to deliver mental health services as approved by the Division.**

**CS.21**            **Community support workers shall have a maximum of 20 clients in their caseload.**

CS.21.A.            For the purposes of this standard, a client seen biweekly will be counted as one-half client, a client seen monthly will be counted as one-quarter client and a client seen quarterly will be counted as one-thirteenth client.

CS.21.B.            In instances in which the agency has compelling reasons for not meeting this standard, those reasons will be documented as well as efforts being taken to achieve compliance with the standard.

CS.21.C.            In no case shall the ratio of community support workers to clients exceed 1:40.

## **CRISIS RESIDENTIAL SERVICE STANDARDS**

These standards, in addition to the core standards, are applied to agencies providing crisis residential services.

### **Assessment**

**CRS.1**    **An assessment of the client is completed within 24 hours of admission to the crisis residential program.**

CRS.1.A.            The assessment minimally addresses the following:

CRS.1.A.1            the client's strengths and weaknesses;

CRS.1.A.2            the client's perception of his or her needs;

CRS.1.A.3            the family/guardian's input and perception of the client's needs when appropriate, and with the client's consent;

CRS.1.A.4            a personal, family, and social history;

CRS.1.A.5            the client's emotional, psychiatric and psychological strengths and needs;

CRS.1.A.6            a physical health status and history, including current prescribed and over-the-counter medication use;

CRS.1.A.7            past and current drug/alcohol use;

- CRS.1.A.8 a developmental history;
- CRS.1.A.9 possible sources of assistance and support in meeting the needs expressed by the client or legally responsible party, including state and federal entitlement programs;
- CRS.1.A.10 physical and environmental barriers that may impede the client and family's ability to obtain services;
- CRS.1.A.11 history of physical and/or sexual abuse;
- CRS.1.A.12 housing and financial needs; and
- CRS.1.A.13 the signature of the person who performed the assessment.

**Interpretive Guideline for CRS.1.A through CRS.1.A.13**

The Division of Licensing recognizes that in some cases not all of the information requested in these standards will be able to be obtained. The Division also recognizes that the level of detail required will vary given a variety of factors (the client's level of cooperation, the integrity of information sources, the length of services or treatment, the condition being addressed, the practitioner's training, etc.). Although the Division will attempt to be sensitive to these factors and flexible in surveying this area, the agency should assure that assessments that do not address all these standards have accompanying documentation that justifies abbreviated or absent information.

- CRS.1.B. The agency will establish policies and procedures establishing criteria for the performance of the following assessments:
  - CRS.1.B.1 a nutritional assessment;
  - CRS.1.B.2 a cognitive functioning assessment;

**Interpretive Guideline for CRS.1.B.2**

The client's cognitive functioning assessment should include assessment of the following functions: problem solving, decision making, organization, self-direction, system negotiation skills, concentration, and abstract reasoning. For individuals over 60 years of age, this assessment should also include memory, language, orientation, and visuo-spatial abilities.

- CRS.1.B.3 an assessment of the client's capacity;
- CRS.1.B.4 a neurological assessment.
- CRS.1.C. The assessment shall be obtained from the client, legally responsible party, community service agencies, and to the extent possible, from other individuals in the community as authorized by the client or legally responsible party.
  - CRS.1.C.1. In instances in which the client receives community support services and/or has an Individualized Support Plan, the agency

will, subject to the client's consent, shall coordinate the assessment and subsequent service planning with the community support provider.

CRS.1.C.1.a. Services provided to these clients will be consistent with the targets and objectives of the Individualized Support Plan.

CRS.1.C.1.b. Services provided to these clients will be delivered pursuant to a service agreement negotiated with the community support worker.

CRS.1.D. The client record contains a summary evaluation of the data collected in the assessment.

**Interpretive Guideline for CRS.1.B through CRS.1.B.4**

These assessments do not necessarily have to be performed in the agency or by agency staff. The intent of these standards are to assure that the agency has mechanisms by which to evaluate the need for these assessments and to perform or refer for assessment those clients whose symptomatology suggests such need.

**Service Planning**

**CRS.2 A service plan is developed for each client, with the client's consent, within 24 hours of admission to the crisis residential program.**

CRS.2.A. The service plan minimally contains the following:

- CRS.2.A.1 problem statements;
- CRS.2.A.2 goals related to the projected length of stay and based upon client needs;
- CRS.2.A.3 objectives stated in terms which allow objective measurement of progress;
- CRS.2.A.4 specification of treatment responsibilities and methods;
- CRS.2.A.5 client input and signature;
- CRS.2.A.6 signatures of all people participating in the development of the plan;
- CRS.2.A.7 a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals;
- CRS.2.A.8 criteria for discharge.

**Interpretive Guideline for CRS.2.A.7 through CRS.2.A.8**

These elements may be addressed within service plan goals.

**CRS.3 The service plan is designed so that the client's progress towards service plan goals can be monitored**

and evaluated.

### **Discharge Planning**

**CRS.4 A discharge summary is entered in the client record within 24 hours of discharge and includes the client's course of treatment and ongoing needs at discharge.**

CRS.4.A. Each discharge minimally addresses, but need not be limited to, the following:

CRS.4.A.1 the reasons for termination of service;

CRS.4.A.2 the final assessment, including general observations and significant findings of the client's condition initially, while services were being provided and at discharge;

CRS.4.A.3 the course and progress of the client with regard to each identified problem; and

CRS.4.A.4 the recommendations and arrangements for further continued service needs.

**CRS.5 The agency will have a discharge protocol that protects the client from summary discharge and allows the agency to maintain program integrity.**

CRS.5.A. The agency has a policy and procedure for discharging clients that includes the terms upon which a client may be discharged (e.g., serious infractions of the policies required to maintain the privacy, comfort and safety of residents, under-utilization of the program).

CRS.5.B. Agencies will not summarily discharge clients. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

### **Physical Plant**

**CRS.6 A secure and readily accessible storage area of adequate size is available to accommodate client belongings.**

CRS.6.A. The agency has a policy and procedure related to what personal belongings may be brought to the agency.

### **Crisis Residential Services**

**CRS.7 All agencies will have personal emergency paging systems or will have staff back-up assistance immediately available.**

CRS.7.A. Agencies that do not have a personal emergency paging system will have policies and procedures assuring the immediate availability of staff back-up assistance.

**CRS.8 In addition to the orientation and training required in the core staff development standards, crisis residential staff shall:**

CRS.8.A. "shadow" an experienced staff member for an appropriate period (determined by the agency in policy and procedure);

- CRS.8.B. receive nationally recognized training in managing people who act out aggressively (e.g. MANDT, Nappi);
- CRS.8.C. receive training in crisis stabilization;
- CRS.8.D. receive training in residential/milieu management.

## Health

### **CRS.9 If food services are provided, the facilities for the preparation and serving of food shall be inspected and approved by the Department of Human Services.**

- CRS.9.A. If food is either prepared or served at the facility, then the agency shall either obtain a DHS Eating Establishment license or show written evidence from DHS indicating that they need no such license.
- CRS.9.B. When the agency requires a DHS license, the agency's Eating Establishment license is current.

### **CRS.10 The agency shall have methods for obtaining on- or off-site medical services for all clients.**

- CRS.10.A. The agency defines in policy and procedure those medical services delivered on-site. For those medical services not provided on-site, letters of agreement and/or procedures for accessing medical service provider(s) are in effect.

## **EMERGENCY SERVICE STANDARDS**

These standards, in addition to the core standards, are applied to agencies providing emergency services.

## Assessment

### **EM.1 There is documented evidence that the results of the assessment are discussed with the individual and/or the legally responsible party as appropriate.**

#### **Interpretive Guideline for EM.1**

If the results are not discussed with the client or legally responsible party, the agency documents the reason(s) for not communicating this information.

## Emergency Services

### **EM.2 A plan will be developed through an assessment of the client's immediate treatment, supervision, and support needs.**

EM.2.A. There is documented evidence that the agency assesses the individuals they serve.

EM.2.B. Every record of emergency contact or set of contacts around a particular incident will include documentation of the:

EM.2.B.1 presenting problem;

- EM.2.B.2 history and precipitating factors;
- EM.2.B.3 assessing capacity to make reasoned decisions, danger to self or others, and ability to care for self; and
- EM.2.B.4 disposition, including referrals to other services as appropriate and indicated.

EM.2.C. In instances in which the emergency services personnel are aware that the client receives community support services and/or has an Individualized Support Plan, the agency will, subject to the client's consent and the availability of the community support worker, shall coordinate the assessment and planning with the community support worker.

- EM.2.C.1 Services provided to these clients will be consistent with the targets and objectives of the Individualized Support Plan.

**Interpretive Guideline for EM.2**

A client's refusal or inability to consent is documented in the client record.

- EM.3 Crisis and emergency workers collaborate with the client to determine the most appropriate, least restrictive environment for the client's stabilization and indicate this collaboration in progress notes.**

**Interpretive Guideline for EM.3**

Crisis and emergency workers consider four options in priority order for least restrictive environment:

1. return to client's home or home of a family member or friend;
2. stabilization in a short-term supported bed;
3. voluntary admission to a psychiatric facility; or
4. hospitalization in a secure facility.

- EM.4 The agency has documented evidence that trained intervention personnel have consultation services of a psychologist or a psychiatrist available to them at all times.**

- EM.5 The agency maintains contact/progress notes on each client that include follow-up evaluations on the outcome of services and referrals.**

- EM.6 Crisis services shall be delivered in a timely fashion and be available 24 hours per day, seven days per week.**

EM.6.A. Trained crisis workers are available at all times through face-to-face or phone contact.

EM.6.B. The agency determines criteria for timeliness and monitors compliance with these criteria by documenting when a request for emergency service is made and when emergency services are delivered.

EM.6.C. There are no substantiated complaints regarding access to emergency services. All substantiated complaints will be assessed for the seriousness of the

violation and actions taken to achieve compliance.

**EM.7 The agency has the capacity to provide face-to-face contact during normal business hours.**

EM.7.A. There are no substantiated complaints regarding refusal of face-to-face contact during normal business hours. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**EM.8 All agencies have a capability, either directly or through arrangement, to assure face-to-face contacts off-site when necessary.**

EM.8.A. Agencies will have a written policy and procedure regarding steps to be taken when face-to-face contact with the client appears necessary. This document should minimally include procedures for contacting emergency service providers, e.g., police, EMTs, rescue, mobile crisis teams, or other professional emergency response organizations.

EM.8.B. All crisis service agencies have access to personnel capable of processing involuntary hospitalizations, either directly or through written agreements.

**EM.9 The agency has written criteria and documents follow-up contacts with clients who are at risk.**

EM.9.A. Follow-up contacts are documented in the client's record and comply with confidentiality and informed consent standards.

**Interpretive Guideline for EM.9**

There are written criteria describing the process for follow-up contacts with clients at risk. This may include, but is not necessarily limited to the following: contacting other agencies, encouraging clients to call back, and directly calling clients who consent to such follow-up.

**EM.10 The agency develops intervention plans for clients with frequent or special needs.**

EM.10.A. The agency has written criteria and a process for developing intervention plans based upon frequency of contacts and acuity of needs.

EM.10.A.1 There is documented evidence that the intervention plan is developed with the participation of the client, legally responsible party and other representatives and professionals whom the client designates.

EM.10.B. There is documented evidence that intervention plans are periodically reviewed.

**EM.11 There are written procedures to access rescue services, including a plan to update resource listings routinely.**

EM.11.A. There is documented evidence that rescue procedures are routinely followed and are systematically revised and updated.

EM.11.B. There is evidence that staff members are trained in the agency's rescue

procedures.

**EM.12 The agency has documented evidence that services to victims/survivors of rape/incest are either provided directly or through referral.**

EM.12.A. If services are provided by the agency, there is documented evidence that staff members have received training relative to these services.

EM.12.B. If services are not provided directly by the agency, the agency has a written policy and procedure regarding referral of these clients to a provider of these services.

**EM.13 Crisis or emergency workers shall be licensed or certified to deliver mental health services in the State and have additional training in the delivery of emergency services.**

## **INPATIENT SERVICE STANDARDS**

These standards, in addition to the core standards, are applied to agencies providing inpatient services.

### **Access .**

**IN.1 The agency has policies and procedures governing the establishment of a waiting list for non-emergency admissions, that minimally includes the following: prioritizing clients, selecting clients from the waiting list, and referring clients to other providers.**

### **Assessment.**

**IN.2 A comprehensive assessment is conducted by an individual chosen or agreed to by client, with the client's participation, within 10 working days of the client's admission.**

IN.2.A. The comprehensive assessment minimally addresses the following:

IN.2.A.1 the client's strengths and weaknesses;

IN.2.A.2 the client's perception of his or her needs;

IN.2.A.3 the family/guardian's input and perception of the client's needs when appropriate, and with the client's consent;

IN.2.A.4 a personal, family, and social history;

IN.2.A.5 emotional and psychological strengths and needs;

IN.2.A.6a psychiatric status and history, including, subject to the client's consent, records of previous psychiatric hospitalizations and services received by the client in the community, including crisis services;

IN.2.A.7a physical health status and history, including current prescription and over-the-counter medication use;

IN.2.A.8 past and current drug/alcohol use;

IN.2.A.9a developmental history;

IN.2.A.10 possible sources of assistance and support in meeting the needs expressed by the client or legally responsible party, including state and federal entitlement programs;

IN.2.A.11 physical and environmental barriers that may impede the client and family's ability to obtain services;

IN.2.A.12 history of physical and/or sexual abuse;

IN.2.A.13 the vocational, educational, social, living, leisure/recreation and medical domains;

IN.2.A.14 the signature of the person who performed the assessment.

**Interpretive Guideline for IN.2.A.1 thru IN.2.A.14**

The Division of Licensing recognizes that in some cases not all of the information requested in these standards will be able to be obtained. The Division also recognizes that the level of detail required will vary given a variety of factors (the client's level of cooperation, the integrity of information sources, the length of services or treatment, the condition being addressed, the practitioner's training, etc.). Although the Division will attempt to be sensitive to these factors and flexible in surveying this area, the agency should assure that assessments that do not address all these standards have accompanying documentation that justifies abbreviated or absent information.

IN.2.B. The agency will establish policies and procedures establishing criteria for the performance of the following assessments:

IN.2.B.1 a nutritional assessment;

IN.2.B.2 a cognitive functioning assessment:

**Interpretive Guideline for IN.2.B.2**

The client's cognitive functioning assessment should include assessment of the following functions: problem solving, decision making, organization, self-direction, system negotiation skills, concentration, and abstract reasoning. For individuals over 60 years of age, this assessment should also include memory, language, orientation, and visuo-spatial abilities.

IN.2.B.3 an assessment of the client's capacity to make reasoned decisions;

IN.2.B.4 a neurological assessment.

**Interpretive Guideline for IN.2.B thru IN.2.B.4**

These assessments do not necessarily have to be performed in the agency or by agency staff. The intent of these standards are to assure that the agency has mechanisms by which to evaluate the need for these assessments and to perform or refer for assessment those clients whose symptomatology suggests the need for these assessments.

IN.2.C The assessment(s) shall be obtained from the client, legally responsible party, community service agencies, and to the extent possible, from other individuals in the community as authorized by the client or legally responsible party.

IN.2.C.1. In instances in which the client receives community support services and/or has an Individualized Support Plan, the agency will, subject to the client's consent, attempt to coordinate the assessment and subsequent treatment planning with the community support provider.

IN.2.C.1.a. Services provided to these clients will be consistent with the targets and objectives of the Individualized Support Plan.

IN.2.D The client record contains a summary evaluation of the data collected in the comprehensive assessment.

**IN.3 The agency has a documented policy and procedure on updating assessments that assures that assessments are current and in no case exceed annual updates.**

**Treatment Planning**

**IN.4 There is documented evidence that the treatment planning and revision process involves the client, legally responsible party, and other representatives and professionals whom the client designates.**

**Interpretive Guideline for IN.4**

The client and legally designated guardian shall be fully and actively involved in the development or revision of the service plan, if possible. All individuals designated by the client, including the representative, family members or significant others (so designated by the client) shall be included in the development and revision of the service plan, unless contraindicated. When these individuals do not attend, their absence is noted. Each agency shall document good faith efforts, including 24 hour notice of any service planning meetings, to involve guardians, representatives or legally responsible parents.

**IN.5 A treatment plan is developed for each client, with the client's consent, and within 3 working days of admission.**

IN.5.A. The treatment plan minimally contains the following:

IN.5.A.1 problem statements;

IN.5.A.2 short- and long-range goals based upon client needs with a projection of when such goals will be attained;

IN.5.A.3 objectives stated in terms which allow objective measurement of progress;

IN.5.A.4 multi-disciplinary input and specification of treatment responsibilities;

IN.5.A.5 client input and signature;

IN.5.A.6 signatures of all people participating;

IN.5.A.7 the methods and frequency of treatment, rehabilitation, support;

IN.5.A.8 a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals; and

IN.5.A.9 criteria for discharge or release to a less restrictive setting.

IN.5.B Justification for not addressing problems identified in the assessments is documented in the client record.

**Interpretive Guideline for IN.5.B**

The intent of this standard is to assure that the clinical staff considers all of the client's identified problems in formulating the service plan. Problems that are not reflected on the service plan should have accompanying documentation identifying the rationale for not addressing the problems at this time. This documentation can take many forms including progress notes, service plan narratives, etc.

**IN.6 The treatment plan is designed so that the client's progress towards treatment plan goals can be monitored and evaluated.**

**Interpretive Guideline for IN.6**

Service plans should have measurable goals and some means for reflecting when, or to what degree, a goal has been attained. The organization should also have mechanisms that document monitoring and evaluation of client goals, e.g., quality assessment, treatment plan review documents.

**IN.7 The treatment plan is reviewed at major decision points in each client's treatment course, upon client request, and no less frequently than every 30 days.**

**Interpretive Guideline for IN.7**

Major decision points may include, but are not necessarily limited to the following: when there is a change in the client's condition, when a service appears not to benefit the client, when the client is under- or over-utilizing services.

**IN.8 Unmet service needs are documented in the treatment plan.****Interpretive Guideline for IN.8**

If at the time of the service planning meeting, team members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the client. The organization should also document notification of the organization's leadership and the Commissioner regarding the unavailability of service that is causing the unmet service need.

**IN.9 The agency has a policy and procedure for providing clients with a copy of their treatment plan within one week following its formulation, review or revision and notification of client recourse should they disagree with any aspect of the plan.**

IN.9.A. The agency will not fail to provide a copy of the client's treatment plan and/or notify them of recourse should they disagree.

**Discharge Planning****IN.10 Each client record contains documentation of current discharge or termination planning as required by IN.5.****IN.11 A discharge summary is entered in the client record within 15 days of discharge and includes the client's course of treatment and ongoing needs at discharge.**

IN.11.A. Each discharge summary minimally addresses, but need not be limited to the following:

- IN.11.A.1 the reasons for termination of service;
- IN.11.A.2 the final assessment, including the general observations and significant findings of the client's condition initially, while services were being provided and at discharge;
- IN.11.A.3 the course and progress of the client with regard to each identified problem;
- IN.11.A.4 the recommendations and arrangements for further continued service needs.

**IN.12 The agency documents the client's stated preference for living situation in the discharge plan.**

#### **Interpretive Guideline for IN.12**

When the client's preference for living situation cannot be accommodated, the reasons are documented.

**IN.13            Applicants who are not eligible for services will be referred to appropriate services, if required, available and desired.**

IN.13.A. The agency has a policy and procedure on referral and/or transfers of individuals deemed inappropriate for services offered by the agency that minimally includes communicating the rationale for the referral/transfer to the applicant and providing them with a list of alternative service providers and advocacy services.

IN.13.B. The agency provides and documents other assistance as required to assist the individual to obtain/access the services to which they are referring him/her.

#### **Health**

**IN.14            If food services are provided, the facilities for the preparation and serving of food shall be inspected and approved by the Department of Human Services.**

IN.14.A. If food is either prepared or served at the facility, then the agency shall either a DHS Eating Establishment license or show written evidence from DHS indicating that they need no such license.

IN.14.B. When the agency requires a DHS license, the agency's Eating Establishment license is current.

**IN.15            The agency shall have methods for obtaining on- or off-site medical services for all clients.**

IN.15.A. The agency defines in policy and procedure those medical services delivered on-site. For those medical services not provided on-site, letters of agreement and/or procedures for accessing medical service provider(s) are in effect.

#### **Physical Plant**

**IN.16            A secure and readily accessible storage area of adequate size is available to accommodate client belongings.**

IN.16.A. The agency has a policy and procedure related to what personal belongings may be brought to the agency.

#### **Inpatient Services**

**IN.17            Inpatient agencies meet all other mandatory regulatory standards applicable to their organization, e.g., Medicare, Medicaid, DHS Hospital Licensure.**

**IN.18            Clients who request community support services while in an inpatient psychiatric facility are assigned a community support worker within two working days.**

IN.18.A. The clients request for community support services is documented in the client record and minimally includes the date and time of the request.

IN.18.B. The agency documents contacting a community support agency within one

working day to allow the community support agency adequate time to assign a community support worker.

IN.18.C. The requesting client's record reflects the date and time when a community support worker was assigned and the community support worker's name.

IN.18.D. There is evidence that the community support worker has participated in treatment and discharge planning meetings to coordinate service planning.

**IN.19 For clients with prior inpatient hospitalizations, the admitting hospital requests the client's consent to release previous records, obtains them in a timely fashion, and considers them in treatment and discharge planning.**

IN.19.A. Upon learning that a client has had a prior psychiatric hospitalization, the individual coordinating the client's treatment shall request the client's consent to the release of records.

IN.19.B. Within two days of consent to release, the individual coordinating the client's treatment, sends for copies of the records.

IN.19.C. Where prior records are obtained, there is evidence in the treatment and discharge planning that the team considered additional information from records of previous hospitalizations.

**IN.20 Each inpatient service minimally provides the following treatment services: individual, group, and family therapy, medication evaluation and administration.**

IN.20.A. The agency can document that each client is offered individual counseling with a psychiatrist, psychologist, clinical social worker, psychiatric nurse, or a psychiatric physician extender for sessions totalling no less than 3 hours per week.

IN.20.B. Each client is evaluated for the need for medication.

## **OUTPATIENT SERVICE STANDARDS**

These standards, in addition to the core standards, are applied to agencies providing outpatient services.

### **Access**

**OP.1 The agency has policies and procedures governing the establishment of a waiting list, that minimally includes the following: prioritizing clients, selecting clients from the waiting list, and referring clients to other providers.**

### **Assessment**

**OP.2 A comprehensive assessment is conducted by an individual chosen or agreed to by the client, with the client's participation, within 30 days of the client agreeing to initiate services.**

OP.2.A. The comprehensive assessment minimally addresses the following:

- |           |   |
|-----------|---|
| OP.2.A.1  | the client's strengths and weaknesses;  |
| OP.2.A.2  | the client's perception of his or her needs;  |
| OP.2.A.3  | the family/guardian's input and perception of the client's needs when appropriate, and with the client's consent;   |
| OP.2.A.4  | a personal, family, and social history;   |
| OP.2.A.5  | a psychiatric status and history;   |
| OP.2.A.6  | a physical health status and history, including current prescription and over-the-counter medication use;   |
| OP.2.A.7  | past and current drug/alcohol use;  |
| OP.2.A.8  | a developmental history;  |
| OP.2.A.9  | possible sources of assistance and support in meeting the needs expressed by the client or legally responsible party, including state and federal entitlement programs; |
| OP.2.A.10 | physical and environmental barriers that may impede the client and family's ability to obtain services;   |
| OP.2.A.11 | history of physical and/or sexual abuse;  |
| OP.2.A.12 | the vocational, educational, social, living, leisure/recreation and medical domains;  |
| OP.2.A.13 | the signature of the person who performed the assessment.   |

**Interpretive Guideline for OP.2.A.1 thru OP.2.A.13**

The Division of Licensing recognizes that in some cases not all of the information requested in these standards will be able to be obtained. The Division also recognizes that the level of detail required will vary given a variety of factors (the client's level of cooperation, the integrity of information sources, the length of services or treatment, the condition being addressed, the practitioner's training, etc.). Although the Division will attempt to be sensitive to these factors and flexible in surveying this area, the agency should assure that assessments that do not address all these standards have accompanying documentation that justifies abbreviated or absent information.

OP.2.B. The agency will establish policies and procedures establishing criteria for the performance of the following assessments:

- |          |                                     |
|----------|-------------------------------------|
| OP.2.B.1 | a nutritional assessment;           |
| OP.2.B.2 | a cognitive functioning assessment; |

#### **Interpretive Guideline for OP.2.B.2**

The client's cognitive functioning assessment should include assessment of the following functions: problem solving, decision making, organization, self-direction, system negotiation skills, concentration, and abstract reasoning. For individuals over 60 years of age, this assessment should also include memory, language, orientation, and visuo-spatial abilities.

OP.2.B.3            an assessment of the client's capacity;

OP.2.B.4            a neurological assessment.

#### **Interpretive Guideline for OP.2.B thru OP.2.B.4**

These assessments do not necessarily have to be performed in the agency or by agency staff. The intent of these standards are to assure that the agency has mechanisms by which to evaluate the need for these assessments and to perform or refer for assessment those clients whose symptomatology suggests the need for these assessments.

OP.2.C            The assessment(s) shall be obtained from the client, legally responsible party, community service agencies, and to the extent possible, from other individuals in the community as authorized by the client or legally responsible party.

OP.2.C.1.        In instances in which the client receives community support services and/or has an Individualized Support Plan, the agency will, subject to the client's consent, attempt to coordinate the assessment and subsequent service planning with the community support provider.

OP.2.C.1.a.      Services provided to these clients will be consistent with the targets and objectives of the Individualized Support Plan.

OP.2.C.1.b.      Services provided to these clients will be delivered pursuant to a service agreement negotiated with the community support worker.

OP.2.D            The client record contains a summary evaluation of the data collected in the comprehensive assessment.

**OP.3            The agency has a documented policy and procedure on updating assessments that assures that assessments are current and in no case exceed annual updates.**

## Service Planning

- OP.4**            **There is documented evidence that the service planning and revision process involves the client, legally responsible party, and other representatives and professionals whom the client identifies.**

### **Interpretive Guideline for OP.4**

The client and legally designated guardian shall be fully and actively involved in the development or revision of the service plan, if possible. All individuals designated by the client, including the representative, family members or significant others (so designated by the client) shall be included in the development and revision of the service plan, unless contraindicated. When these individuals do not attend, their absence is noted. Each agency shall document good faith efforts, including 3 days notice of any service planning meetings, to involve guardians, representatives or legally responsible parents.

- OP.5**            **A comprehensive service plan is developed for each client, with the client's consent, and within 30 days of initiation of service.**

OP.5.A. The comprehensive service plan minimally contains the following:

- |          |  |
|----------|--|
| OP.5.A.1 | problem statements;  |
| OP.5.A.2 | short- and long-range goals based upon client needs with a projection of when such goals will be attained;   |
| OP.5.A.3 | objectives stated in terms which allow objective measurement of progress;  |
| OP.5.A.4 | multi-disciplinary input and specification of treatment responsibilities;  |
| OP.5.A.5 | client input and signature;  |
| OP.5.A.6 | signatures of all people participating in the development of the plan;   |
| OP.5.A.7 | the methods and frequency of treatment, rehabilitation, support;   |
| OP.5.A.8 | a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals; and |
| OP.5.A.9 | criteria for discharge.  |

OP.5.B Justification for not addressing problems identified in the assessments is documented in the client record.

**Interpretive Guideline for OP.5.B**

The intent of this standard is to assure that the clinical staff considers all of the client's identified problems in formulating the service plan. Problems that are not reflected on the service plan should have accompanying documentation identifying the rationale for not addressing the problems at this time. This documentation can take many forms including progress notes, service plan narratives, etc.

- OP.6            The service plan is designed so that the client's progress towards service plan goals can be monitored and evaluated.**

**Interpretive Guideline for OP.6**

Service plans should have measurable goals and some means for reflecting when, or to what degree, a goal has been attained. The organization should also have mechanisms that document monitoring and evaluation of client goals (e.g., QA monitoring, treatment plan review documents).

- OP.7            The service plan is reviewed at major decision points in each client's treatment course, upon client request, and no less frequently than every 90 days.**

**Interpretive Guideline for OP.7**

Major decision points may include, but are not necessarily limited to the following: when there is a change in the client's condition, when a service appears not to benefit the client, when the client is under- or over-utilizing services.

- OP.8            Unmet service needs are documented in the service plan.**

- OP.9            The agency has a policy and procedure for providing clients with a copy of their service plan within one week following its formulation, review or revision and notification of client recourse should they disagree with any aspect of the plan.**

**Interpretive Guideline for OP.8**

If at the time of the service planning meeting team members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the client. The organization should also document notification of the organization's leadership and the Commissioner regarding the unavailability of service that is causing the unmet service need.

- OP.9.A.        The agency will not fail to provide a copy of the client's service plan and/or notify them of recourse should they disagree.**

**Discharge Planning**

- OP.10    Each client record contains documentation of current discharge or termination planning.**

- OP.11    The agency has discharge planning policies and procedures.**

OP.11.A The agency has a policy and procedure for determining when a client is considered "inactive".

OP.11.A.1 The inactive status policy and procedure notes what documentation is kept on the client during inactive status.

OP.11.A.2 The inactive status policy and procedure notes the duration of inactive status before the case is considered closed.

**OP.12 A discharge summary is entered in the client record within 15 days of discharge or on the 90th day of inactive status and includes the client's course of treatment and ongoing needs at discharge.**

OP.12.A Each discharge summary minimally addresses, but need not be limited to the following:

OP.12.A.1 the reasons for termination of service;

OP.12.A.2 the final assessment, including general observations and significant findings of the client's condition initially, while services were being provided and at discharge;

OP.12.A.3 the course and progress of the client with regard to each identified problem; and

OP.12.A.4 the recommendations and arrangements for further continued service needs.

**Interpretive Guideline for OP.12**

For clients on inactive status, a discharge summary should be completed no later than 90 days following placement on inactive status or earlier given the following conditions:

1. another agency submits a request for the client's discharge summary prior to the 90th day of inactive status;

2. agency policy requires that a discharge summary be completed earlier than the 90th day of inactive status; and

3. practitioners who are leaving agency employment must complete discharge summaries on all of their inactive status clients regardless of time frame.

**OP.13 The agency has policies and procedures that specify under what conditions services may be discontinued or interrupted which minimally include how and when the client is notified.**

OP.13.A. For agencies serving DMHMR class members, the agency shall first obtain prior written approval for discontinuing or interrupting services from the Department.

OP.13.B For agencies serving DMHMR class members, the agency shall give thirty days advance written notice to the client and the client's guardian. If the client poses a threat of imminent harm to persons employed or served by the agency, the agency shall give notice that is reasonable under the

circumstances.

OP.13.C For agencies serving DMHMR class members, the agency shall give such notice as may be required by law or regulation.

OP.13.D For agencies serving DMHMR class members, the agency shall assist the client in obtaining the services from another agency.

OP.13.E For agencies serving DMHMR class members, the agency shall provide documented evidence in the client record of compliance with these standards, through letters, progress notes, phone logs, and/or facsimile.

**OP.14 Applicants, who are not eligible for services, will be referred to appropriate services, if required, available and desired.**

OP.14.A. The agency has a policy and procedure on referral and/or transfers of individuals deemed inappropriate for services offered by the agency that minimally includes communicating the rationale for the referral/transfer to the applicant and providing them with a list of alternative service providers and advocacy services.

OP.14.B. The agency provides and documents other assistance as required to assist the individual to obtain/access the services to which they are referring him/her.

**Health**

**OP.15 If food services are provided, the facilities for the preparation and serving of food shall be inspected and approved by the Department of Human Services.**

OP.15.A. If food is either prepared or served at the facility, then the agency shall either a DHS Eating Establishment license or show written evidence from DHS indicating that they need no such license.

OP.15.B. When the agency requires a DHS license, the agency's Eating Establishment license is current.

**OP.16 The agency shall have methods for obtaining on- or off-site medical services for all clients.**

OP.16.A. The agency defines in policy and procedure those medical services delivered on-site. For those medical services not provided on-site, letters of agreement and/or procedures for accessing medical service provider(s) are in effect.

## RESIDENTIAL SERVICE STANDARDS

These standards, in addition to the core standards, are applied to agencies providing residential services.

### Access

**RS.1            The agency has policies and procedures governing the establishment of a waiting list, that minimally includes the following: prioritizing clients, selecting clients from the waiting list, and referring clients to other providers.**

RS.1.A. Policies and procedures governing the establishment of waiting lists and the selection of clients will be in compliance with the Fair Housing Amendments Act.

### Assessment

**RS.2            A comprehensive assessment is conducted by an individual chosen or agreed to by the client or legally responsible party, with the client's participation, within 20 working days of the client's admission.**

RS.2.A. The comprehensive assessment minimally addresses the following:

- |           |   |
|-----------|---|
| RS.2.A.1  | the client's strengths and weaknesses;  |
| RS.2.A.2  | the client's perception of his or her needs;  |
| RS.2.A.3  | the family/guardian's input and perception of the client's needs when appropriate, and with the client's consent;   |
| RS.2.A.4  | a personal, family, and social history;   |
| RS.2.A.5  | the client's emotional, psychiatric and psychological strengths and needs;  |
| RS.2.A.6  | a physical health status and history, including current prescription and over-the-counter medication use;   |
| RS.2.A.7  | past and current drug/alcohol use;  |
| RS.2.A.8  | a developmental history;  |
| RS.2.A.9  | possible sources of assistance and support in meeting the needs expressed by the client or legally responsible party, including state and federal entitlement programs; |
| RS.2.A.10 | physical and environmental barriers that may impede the client and family's ability to obtain services;   |
| RS.2.A.11 | history of physical and/or sexual abuse;  |
| RS.2.A.12 | the vocational, educational, social, living, leisure/recreation   |

and medical domains;

RS.2.A.13 the signature of the person who performed the assessment.

**Interpretive Guideline for RS.2.A.1 thru RS.2.A.13**

The Division of Licensing recognizes that in some cases not all of the information requested in these standards will be able to be obtained. The Division also recognizes that the level of detail required will vary given a variety of factors (the client's level of cooperation, the integrity of information sources, the length of services or treatment, the condition being addressed, the practitioner's training, etc.). Although the Division will attempt to be sensitive to these factors and flexible in surveying this area, the agency should assure that assessments that do not address all these standards have accompanying documentation that justifies abbreviated or absent information.

RS.2.B. The agency will establish policies and procedures establishing criteria for the performance of the following assessments:

RS.2.B.1 a nutritional assessment;

RS.2.B.2 a cognitive functioning assessment;

**Interpretive Guideline for RS.2.B.2**

The client's cognitive functioning assessment should include assessment of the following functions: problem solving, decision making, organization, self-direction, system negotiation skills, concentration, and abstract reasoning. For individuals over 60 years of age, this assessment should also include memory, language, orientation, and visuo-spatial abilities.

RS.2.B.3 an assessment of the client's capacity to make reasoned decisions;

RS.2.B.4 a neurological assessment.

**Interpretive Guideline for RS.2.B thru RS.2.B.4**

These assessments do not necessarily have to be performed in the agency or by agency staff. The intent of these standards are to assure that the agency has mechanisms by which to evaluate the need for these assessments and to perform or refer for assessment those clients whose symptomatology suggests the need for these assessments.

RS.2.C The assessment(s) shall be obtained from the client, legally responsible party, community service agencies, and to the extent possible, from other individuals in the community as authorized by the client or legally responsible party.

RS.2.C.1. In instances in which the client receives community support services and/or has an Individualized Support Plan, the agency will, subject to the client's consent,

attempt to coordinate the assessment and subsequent service planning with the community support provider.

RS.2.C.1.a. Services provided to these clients will be consistent with the targets and objectives of the Individualized Support Plan.

RS.2.C.1.b. Services provided to these clients will be delivered pursuant to a service agreement negotiated with the community support worker.

RS.2.D The client record contains a summary evaluation of the data collected in the comprehensive assessment.

**RS.3 The agency has a documented policy and procedure on updating assessments that assures that assessments are current and in no case exceed annual updates.**

#### **Service Planning**

**RS.4 An initial service plan is developed within 72 hours following admission and is based on preliminary assessment findings.**

**RS.5 There is documented evidence that the service planning and revision process involves the client, legally responsible party, and other representatives and professionals whom the client identifies.**

#### **Interpretive Guideline for RS.5**

The client and legally designated guardian shall be fully and actively involved in the development or revision of the service plan, if possible. All individuals designated by the client, including the representative, family members or significant others (so designated by the client) shall be included in the development and revision of the service plan, unless contraindicated. When these individuals do not attend, their absence is noted. Each agency shall document good faith efforts, including 24 hour notice of any service planning meetings, to involve guardians, representatives or legally responsible parents.

**RS.6 A comprehensive service plan is developed for each client, with the client's consent, and within 20 working days of admission.**

RS.6.A. The comprehensive service plan minimally contains the following:

- |          |  |
|----------|--|
| RS.6.A.1 | problem statements;  |
| RS.6.A.2 | short- and long-range goals based upon client needs with a projection of when such goals will be attained; |
| RS.6.A.3 | objectives stated in terms which allow objective measurement of progress;                                  |
| RS.6.A.4 | multi-disciplinary input and specification of treatment responsibilities;                                  |

- |          |  |
|----------|--|
| RS.6.A.5 | client input and signature;  |
| RS.6.A.6 | signatures of all people participating;  |
| RS.6.A.7 | the methods and frequency of treatment, rehabilitation, support;   |
| RS.6.A.8 | a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals; and |
| RS.6.A.9 | criteria for discharge or release to a less restrictive setting.   |

RS.6.B Justification for not addressing problems identified in the assessments is documented in the client record.

**Interpretive Guideline for RS.6.B**

The intent of this standard is to assure that the clinical staff considers all of the client's identified problems in formulating the service plan. Problems that are not reflected on the service plan should have accompanying documentation identifying the rationale for not addressing the problems at this time. This documentation can take many forms including progress notes, service plan narratives, etc.

**RS.7                    The service plan is designed so that the client's progress towards service plan goals can be monitored and evaluated.**

**Interpretive Guideline for RS.7**

Service plans should have measurable goals and some means for reflecting when, or to what degree, a goal has been attained. The organization should also have mechanisms that document monitoring and evaluation of client goals (e.g., QA monitoring, treatment plan review documents).

**RS.8                    The service plan is reviewed at major decision points in each client's treatment course, upon client request, and no less frequently than every 90 days.**

**Interpretive Guideline for RS.8**

Major decision points may include, but are not necessarily limited to the following: when there is a change in the client's condition, when a service appears not to benefit the client, when the client is under- or over-utilizing services.

**RS.9                    Unmet service needs are documented in the service plan.**

#### **Interpretive Guideline for RS.9**

If at the time of the service planning meeting, team members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the client. The organization should also document notification of the organization's leadership and the Commissioner regarding the unavailability of service that is causing the unmet service need.

**RS.10            The agency has a policy and procedure for providing clients with a copy of their service plan within one week following its formulation, review or revision and notification of client recourse should they disagree with any aspect of the plan.**

RS.10.A.        The agency will not fail to provide a copy of the client's service plan and/or notify them of recourse should they disagree.

#### **Discharge Planning**

**RS.11            Each client record contains documentation of current discharge or termination planning, if appropriate.**

RS.11.A.        Planning for discharge to another setting or service will be contingent upon the client's consent to the establishment of such a discharge as a goal.

**RS.12            A discharge summary is entered in the client record within 15 days of discharge and includes the client's course of treatment and ongoing needs at discharge.**

RS.12.A.        Each discharge summary minimally addresses, but need not be limited to the following:

RS.12.A.1       the reasons for termination of service;

RS.12.A.2       the final assessment, including the general observations and significant findings of the client's condition initially, while services were being provided and at discharge;

RS.12.A.3       the course and progress of the client with regard to each identified problem; and

RS.12.A.4       the recommendations and arrangements for further continued service needs.

**RS.13            The agency has policies and procedures that specify under what conditions services may be discontinued or interrupted which minimally include how and when the client is notified.**

RS.13.A. For agencies serving DMHMR class members, the agency shall first obtain prior written approval for discontinuing or interrupting services from the Department.

RS.13.B For agencies serving DMHMR class members, the agency shall give thirty days advance written notice to the client and the client's guardian. If the client poses a threat of imminent harm to persons employed or served by the agency, the agency shall give notice that is reasonable under the circumstances.

RS.13.C For agencies serving DMHMR class members, the agency shall give such notice as may be required by law or regulation.

RS.13.D For agencies serving DMHMR class members, the agency shall assist the client in obtaining the services from another agency.

RS.13.E For agencies serving DMHMR class members, the agency shall provide documented evidence in the client record of compliance with these standards, through letters, progress notes, phone logs, and/or facsimile.

**RS.14 The agency will have a discharge protocol that protects the client from summary discharge and allows the agency to maintain program integrity.**

RS.14.A. The agency has a policy and procedure for discharging clients that include the terms upon which a client may be discharged (e.g., disciplinary reasons, under-utilization of the program).

RS.14.B. Except in emergency cases, clients shall be given 30 days notice before discharge.

RS.14.C. The agency will not summarily discharge client. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**RS.15 The agency documents the client's stated preference for living situation in the discharge plan.**

**Interpretive Guideline for RS.15**

When the client's preference for living situation cannot be accommodated, the reasons are documented.

**RS.16 Applicants who are not eligible for services will be referred to appropriate services, if required, available and desired.**

RS.16.A. The agency has a policy and procedure on referral and/or transfers of individuals deemed inappropriate for services offered by the agency that minimally includes communicating the rationale for the referral/transfer to the applicant and providing them with a list of alternative service providers and advocacy services.

RS.16.B. The agency provides and documents other assistance as required to assist the individual to obtain/access the services to which they are referring him/her.

## Health

**RS.17**      **If food services are provided, the facilities for the preparation and serving of food shall be inspected and approved by the Department of Human Services.**

RS.17.A.      If food is either prepared or served at the facility, then the agency shall either a DHS Eating Establishment license or show written evidence from DHS indicating that they need no such license.

RS.17.B.      When the agency requires a DHS license, the agency's Eating Establishment license is current.

**RS.18**      **The agency shall have methods for obtaining on- or off-site medical services for all clients.**

RS.18.A.      The agency defines in policy and procedure those medical services delivered on-site. For those medical services not provided on-site, letters of agreement and/or procedures for accessing medical service provider(s) are in effect.

## Physical Plant

**RS.19**      **A secure and readily accessible storage area of adequate size is available to accommodate client belongings.**

RS.19.A.      The agency has a policy and procedure related to what personal belongings may be brought to the agency.

## Residential Services

**RS.20**      **Residential service agencies provide or arrange for comprehensive treatment, training and support of clients.**

RS.20.A.      Residential service agencies provide or arrange for support and training in the following areas:

RS.20.A.1      housekeeping and home maintenance skills;

RS.20.A.2      mobility and community transportation skills;

RS.20.A.3      interpersonal relationships, including spouse, family and friends;

RS.20.A.4      health maintenance, including personal hygiene, exercise and fitness, nutrition and diet management, and use of medical services and medicine;

RS.20.A.5      safety practices, including dealing with injuries and life threatening emergencies;

RS.20.A.6      financial management, including techniques of client purchasing, banking, taxes, budgeting and repaying debts;

RS.20.A.7      basic academic skills;

RS.20.A.8      management of personal and legal affairs;

RS.20.A.9      contingency planning, problem-solving, decision-making;

RS.20.A.10	self-advocacy and assertiveness training;
RS.20.A.11	utilization of community services and resources, including laundromats, library, post office, client affairs offices, etc.
RS.20.A.12	recreational and leisure time activities;
RS.20.A.13	work attitude and skills exploration;
RS.20.A.14	menu planning and meal preparation;
RS.20.A.15	use of the telephone;
RS.20.A.16	human sexuality; and
RS.20.A.17	client affairs and rights, including familiarity with warranties, policies and procedures of governmental and community service agencies.

**Interpretive Guideline for RS.20.A through RS.20.A.17.**

For providers of children's residential services, these topics will be addressed as applicable on an age appropriate basis.

**SOCIAL CLUB STANDARDS**

The following standards constitute all the requirements for the operation of social clubs. By their very nature, social clubs demand special consideration in terms of regulation. Due to this fact, social clubs are the only service that need not comply with the generic standards section of these regulations. Select standards from the core generic standards have been modified and included in the standards below. In addition, a social club task force has developed and included social club-specific requirements.

**Access**

**SC.1 Each club shall have in effect a transportation plan that assures accessibility to the club.**

SC.1.A. The agency documents and takes steps to implement a transportation plan that is directed toward assuring reasonable accessibility to all services.

**SC.2 The social club will have a process of determining sufficient hours of operation which places a priority on the needs of the members.**

SC.2.A. Documentation of the process for determining the hours is available for review.

SC.2.B. Documentation exists that the needs of the members are reviewed annually.

SC.2.C. The club documents what alternative solutions are explored if the need for extended hours requested by the members is limited in any way.

**SC.3 The club has documented evidence of membership criteria that minimally includes people with mental illness.**

**Interpretive Guideline for SC.3**

Self report of eligibility is sufficient for membership.

**SC.4                    Membership will not be denied based on inability to pay dues.**

SC.4.A. No individuals will be refused membership due to inability to pay dues. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**SC.5                    The social club applies its eligibility criteria equally and consistently to all members.**

SC.5.A. Eligibility criteria will be consistently applied in all instances. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**SC.6                    There is no discrimination based upon race, color, religion, age, national origin, gender, ancestry, physical or mental handicap, sexual preference, or socio-economic status.**

SC.6.A. There are no substantiated complaints regarding discrimination. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**SC.7                    The club has a policy and procedure that explains what resources will be used or what efforts will be made to assure that club activities and information are available in the language chosen by the club member or potential club member.**

SC.7.A. There are no substantiated complaints by club members or potential club members citing unavailability of activities or information in their language of preference. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**SC.8                    The consumer board or governing body shall ensure that each social club is in compliance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and the Maine Human Rights Act (MHRA).**

SC.8.A. There are no substantiated complaints regarding violation of the ADA, MHRA, or Section 504, including lack of handicapped accessibility. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

SC.8.A.1            Social clubs must notify the Division of complaints pursuant to the above cited laws resulting in a reasonable grounds finding by an external regulatory body (MHRC/EEOC).

SC.8.B. The social club has policies and procedures regarding compliance with the ADA, MHRA and Section 504 including how persons with disabilities may access services.

SC.8.C. All plans for new buildings or renovation of existing buildings receive approval from the State Fire Marshal's office or designess for compliance with the ADA and Section 504.

SC.8.D. All existing buildings will receive approval from DMHMR's Affirmative Action Officer for compliance with the ADA and Section 504.

**Club Member Records**

**SC.9                    The club shall maintain club member records in a manner that provides security.**

SC.9.A. Club records are stored in secure areas such as locked file cabinets.

SC.9.B. Automated record keeping systems have restricted access through access codes or other automated security measures.

SC.9.B.1. There is a back-up system for all automated club member records.

SC.9.C. The club has a policy and procedure regarding personnel who are authorized to have access to records that is in compliance with federal, state, and local laws.

SC.9.D. There is a method for documenting when records are accessed and taken from the area where they are stored (i.e., outguides, logs). This method should minimally document the person's name, title or relation to the club member, date and time taken and returned.

SC.9.E. There are no instances of breaches of confidentiality that result from improper records management. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**SC.10 Social clubs have a policy and procedure on what documentation is to be maintained in club member records.**

**Interpretive Guideline for SC.10**

Documents that would be expected to be found in a club member record include, but are not necessarily limited to, the following: application, emergency contact, incident reports, verification that club member was notified of club rules.

**SC.11 Social clubs maintain club member records per club policy and procedure.**

**SC.12 All documents or entries in the member's record shall be legible, dated and signed (including full name) by the person making the entry, written in ink or typed, and properly corrected as necessary.**

**Club Member Rights**

**SC.13 Social clubs comply with Section A of the Rights of Recipients of Mental Health Services.**

**Social Club Management**

**SC.14. Each social club will have a consumer board made up of and elected by the social club membership.**

SC.14.A. If the social club is a freestanding agency, the governing body will be elected by the social club membership and will be responsible for compliance with all of the standards in this section. For the purposes of this section, "governing body" will be referred to as "consumer board".

SC.14.B. If the social club is a part of a larger organization, the club will have a consumer board elected by the social club membership and will be responsible for compliance with all of the standards in this section.

**SC.15. If the social club is part of a larger organization, the consumer board will be vested with authority**

**for the operation and day-to-day management of the social club.**

**SC.16. The social club consumer board develops bylaws that address the needs and desires of the membership.**

**SC.17. The social club consumer board develops documented rules, policies and procedures necessary for the ongoing daily operation of the social club.**

SC.17.A. The social club rules, policies and procedures will minimally include the following:

SC.17.A.1. a written mission statement, written by the consumer board or governing body, describing its purpose, the activities it provides and its accessibility and that is reviewed on at least an annual basis;

SC.17.A.2. a planning process that bases its short and long term goals and objectives for activities on a periodic analysis of the wants and needs of current or potential members;

SC.17.A.3. a policy and procedure regarding conflict of interest that minimally addresses the definition of conflict of interest and the procedures for resolving these issues; and

SC.17.A.4. documented criteria and process for suspension of members which should be limited to threats, criminal activity and violent or abusive behavior to self, others or property and which will adhere directly to the "right to due process" with regard to grievances as stated in the Rights of Recipients of Mental Health Services.

SC.17.A.4.a. There is documented evidence that the rules and suspension criteria are reviewed with each member.

SC.17.A.4.b. The club will document that members who have been suspended are given the opportunity to engage in the development of a re-entry plan with an authorized representative of the club.

SC.17.A.4.b.1. All re-entry plans will clearly delineate the responsibilities of the re-entering member and the club.

**SC.18. The club rules are fairly applied and administered by the consumer board or governing body.**

SC.18.A. There are no substantiated complaints regarding unfair application or administration of rules by the consumer board or governing body. All substantiated complaints will be assessed for the seriousness of the violation and actions taken to achieve compliance.

**SC.19. If the social club is part of a larger organization, there will be documented evidence of governing body receipt and consideration of the consumer board's input regarding issues and concerns raised by the consumer board and club members.**

**SC.20 The social club has an organizational chart that defines the lines of authority and responsibility for each position.**

**SC.21**            **The social club shall post the original, current license issued by the Department.**  
**SC.22**            **The social club shall report immediately to the Division, any legal proceedings arising out of circumstances related to the social club.**

**SC.23**            **The social club management will provide ongoing and appropriate training to develop and support members as leaders and promote member leadership.**

#### **Marketing**

**SC.24**            **The social club accurately portrays the scope of their activities in audio, visual, or printed materials.**

**SC.25**            **The social club has evidence that its activities are publicized.**

SC.25.A.            There is evidence that public information activities have been implemented.

#### **Financial Management**

**SC.26**            **The governing body is responsible for insuring the establishment and maintenance of sound fiscal practices as evidenced by, the development and periodic review of policies regarding the fiscal practices of the agency.**

SC.26.A.            The governing body reviews the financial status of the agency on a periodic basis, and minimally reviews the agency's annual audit and approves the annual budget.

##### **Interpretive Guideline for SC.26 through SC.26.A**

"Periodic" is to be defined by the governing body. The club will be evaluated on:

1.        the existence of fiscal policies and procedures;
2.        compliance with the governing body's requirements for policy development and periodic policy review; and
3.        the minimum review and approval activities cited in SC.26.A.

**SC.27**            **Where fees are charged, a schedule of fees for services and policies concerning collection of fees shall be made available to each client or their legally responsible party or posted in the facility for public view.**

SC.27.A.            When the fee schedule is not posted for public view, there is documented evidence that clients and/or the legally responsible party have received notification of the fee schedule.

- SC.28 Social clubs will have documented annual audits from an independent Certified Public Accountant verifying that generally accepted accounting practices are being maintained.**

**Interpretive Guideline for SC.28**

The club must contact the Division for written approval of alternative auditing mechanisms.

**Health and Safety**

- SC.29 The social club complies with all applicable health codes.**

- SC.29.A. There are no substantiated health code violations.
- SC.29.B. The social club complies with all health standards in this section.

- SC.30 Any social club not using a public water and/or sewer system shall be inspected and approved by the Department of Human Services.**

- SC.30.A. Any social club without a public water and/or sewer system shall be able to produce a Sanitary Survey report from the Health Engineering Division of the Department of Human Services.
- SC.30.B. Any social club without public water and/or sewer system will have Sanitary Surveys conducted at least every 3 years per Department of Human Services Engineering Division regulation.

- SC.31 The social club has policies and procedures for managing and controlling infections.**

- SC.31.A. The social club has documented evidence that they have implemented policies and procedures regarding the management and control of infections.

**Interpretive Guideline for SC.31 and SC.31.A**

The management and control of infections has become one of the most serious issues for society, in general, to address. The management staff should determine the extent to which their agency, clients, employees, and others are at risk for acquiring and transmitting infections. Based on this determination, the agency should develop and implement reasonable policies and procedures to manage and control the potential for acquiring or transmitting infections.

- SC.32 Social clubs shall be inspected by the State Fire Marshal or the Fire Marshal's designee to assure compliance with the NFPA 101 Life Safety Code (current edition).**

- SC.32.A. Social clubs have biennial letters from the State Fire Marshal or the Fire Marshal's designee assuring compliance with NFPA 101 Life Safety Code and safe occupancy.

- SC.33 Quarterly fire drills are conducted and documented for non-residential services and monthly for residential services per NFPA 101 Life Safety Code (current edition).**

- SC.33.A. There is documented evidence that the agency is in compliance with

fire drill requirements.

**Interpretive Guideline for SC.32 through SC.33**

Consult the current edition of the NFPA 101 Life Safety Code for requirements in each type of occupancy.

**SC.34            The agency has a written disaster and evacuation plan specifying procedures for personnel and designating specific tasks and responsibilities.**

SC.34.A.            The agency disaster plan addresses a variety of pertinent disasters (e.g., fires, power outages, storms).

SC.34.B.            The disaster plan addresses staff preparedness, including staff requirements and the designation of roles and functions, particularly in terms of capabilities and limitations.

**SC.35            There is documented evidence that staff members receive initial and continuing education concerning disaster and evacuation procedures.**

**Human Resource Management**

**SC.36            The social club has written documentation that each person's duties, responsibilities and performance expectations are clearly communicated upon hire.**

**SC.37            Staff members meet minimum qualifications for their job as determined by the requirements of the Division of Public Education.**

**SC.38            Each position in the organization has a job description.**

SC.38.A.            Job descriptions minimally include the following:

SC.38.A.1           title;

SC.38.A.2           supervisor;

SC.38.A.3           supervisees;

SC.38.A.4           duties and responsibilities; and

SC.38.A.5           minimum education, training and experience qualifications

**SC.39            The social club has a policy and procedure that addresses the mechanism by which all employees have access to, or receive a copy of, the personnel policies and procedures.**

SC.39.A.            The social club documents that each employee has reviewed or received a copy of the personnel policies and procedures by way of signature in the employee's personnel file.

#### **Interpretive Guideline for SC.39.A**

Documentation may include a form indicating the employee has reviewed policies/procedures or the distribution of personnel policy handbooks, etc.

- SC.40**            **The social club has policies and procedures for the recruitment, selection, and retention and promotion of employees, volunteers, and students.**
- SC.41**            **The social club has a policy and procedure establishing practices for the termination or temporary layoff of employees, including provision for notification or the employee and mechanisms for appeal.**
- SC.42**            **The social club has a policy and procedure concerning employee grievances that includes notifying employees of the procedure and maintaining confidential communications and records.**
- SC.43**            **Each employee, student and volunteer has a personnel record.**
- SC.43.A.            The social club has a policy and procedure concerning maintaining personnel records for each employee, student or volunteer.
- SC.43.B.            Personnel records should be maintained similarly and contain documentation pertinent to the employee's, student's or volunteer's work, supervision and training.
- SC.44**            **Each personnel file contains information documenting and verifying the positions held by the employee, volunteer or student and their qualifications and experience.**
- SC.44.A.            The personnel record minimally contains the individual's:
- SC.44.A.1            job description;
- SC.44.A.2            copies of appropriate licenses and certifications;
- SC.44.A.3            copies of the employee's diplomas, transcripts or documentation of verbal verification from the school officials citing date and school official contacted;
- SC.44.A.4            records of employee continuing education and training

#### **Interpretive Guidelines for SC.44.A.4**

These records of training may be in the form of certificates noting date, title of training, number of hours or CEU's or other listings of training received with content, date, presenter and length of training documented.

- SC.45**            **An individual's need for training and continuing education is assessed with the individual's participation and documented within 6 months of hire or job change and at least annually thereafter.**
- SC.46**            **All employees, students and volunteers are given a copy of the Rights of Recipients (Adult and/or Children as appropriate).**
- SC.46.A There is documented evidence that all employees, students and volunteers review the applicable sections of the Rights of Recipients (Adult and/or

Children's editions) before commencing the duties of their job and when there is a change in the Rights regulations.

**Interpretive Guideline for SC.46.A**

Documented evidence may be a statement or other documentation, signed and dated by the employee, student or volunteer that confirms that they have reviewed the Rights of Recipients (Adult and/or Children's edition's).

**SC.47            The social club has policies and procedures on access to personnel files that minimally include the following: the employee's right to access, protection of confidential information, secure storage, making record entries, and distribution of information upon staff request.**

SC.47.A.            The social club has policies and procedures that minimally address the following personnel records issues:

SC.47.A.1            who in addition to the employee, has access to personnel records;

SC.47.A.2            how confidential personnel information is protected;

SC.47.A.3            how personnel records are securely stored;

SC.47.A.4            who in addition to the employee may enter information into the personnel records; and

SC.47.A.5            how and to whom information from personnel records may be disseminated.

**SC.48            The social club has a policy and procedure that addresses when a personnel record is considered inactive and what practices are followed in its disposal to assure the employee's confidentiality.**

**SC.49            The social club has documented processes for addressing employee issues, including policies and procedures on employee recognition, supervision, and discipline.**

**SC.50            The social club is an Equal Opportunity Employer.**

SC.50.A.            The governing body or consumer board establishes and adheres to policies and procedures that provide for periodic review and approval of the personnel policies for compliance with federal, state and local laws.

**Interpretive Guideline for SC.50.A**

The definition of "periodic review" is determined by the governing body. Compliance with this standard and the subsequent standard (SC.53.A.1) depend on this definition.

SC.50.B.            The social club will follow personnel policies and procedures as required by federal, state or local laws in all instances.

SC.50.C All social clubs must notify DMHMR of discrimination complaints resulting in a reasonable grounds finding by an external regulatory body

(MHRC/EEOC).

SC.50.D. The social club has received approval from DMHMR Affirmative Action Officer as an Equal Opportunity Employer.

### **Volunteers and Students**

**SC.51** Individuals who work as volunteers for the agency or who are students shall be clearly identified by title as students or volunteers.

**SC.52** Student supervision shall include documenting in their personnel record, contact with the person supervising the student's educational progress.

#### **Interpretive Guideline for SC.52**

If the school does not designate a liaison, documentation of this should be placed in the student's personnel record.

**SC.53** Students or volunteers are supervised by individuals with licensure, certification, or experience in an area germane to the work assigned.

### **Supervision**

**SC.54** The social club shall develop and maintain clear lines of supervision by assuring that each employee, student and volunteer has a supervisor.

SC.54.A. The social club has a table of organization that clearly indicates lines of supervision within the club and if applicable, how the club staff relate to a larger agency.

**SC.55** The social club has a policy and procedure and documented evidence that ongoing supervision is provided for employees, students, and volunteers.

**SC.56** All supervisory personnel will have documented evidence in their personnel records of training in supervision.

### **Quality Management**

Quality management is broadly defined as management philosophies and behavioral and statistical tools aimed at improving quality, customer satisfaction, and profitability. Although all effective quality management processes have distinct similarities, each agency must adopt quality management principles and practices that are sensitive to their organizational culture and effective in their particular setting. For this reason, the Department and the Division of Licensing does not espouse one particular model of quality management. Therefore, the standards in this section relate to an agency's ability to demonstrate that they have an ongoing and effective quality management process that is customer-focused and strives for customer satisfaction.

**SC.57** The agency has a written plan that addresses how the organization currently monitors, evaluates and improves quality.

**SC.58** The agency can demonstrate that it identifies, monitors, and attempts to improve areas deemed to be critical to quality client care.

- SC.59**            **There is documented evidence that quality management activities are conducted on an ongoing and regular basis.**
- SC.60**            **The effectiveness of quality management is assessed and documented at least annually and involves input from clients, family members, guardians, client representatives, staff, and referral sources.**
- SC.61**            **The agency shall have, available for review, insurance policies citing professional and commercial liability coverage for the organization, staff, volunteers, and students.**
- SC.62**            **The agency has a policy and procedure regarding the reporting and recording of adverse and potentially adverse occurrences, including the recording of complaints.**

**Interpretive Guideline for SC.62**

Some examples of adverse or potentially adverse occurrences include, but are not necessarily limited to the following:

1.     deaths;
2.     injuries;
3.     violations of agency policies; and
4.     violations of client rights.

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